



OBSERVATOIRE
FRANÇAIS DES
DROGUES ET DES
TOXICOMANIES

**2005 NATIONAL REPORT (2004 data) TO THE
EMCDDA
by the Reitox National Focal Point**

**FRANCE
New Development, Trends and in-depth
information on selected issues**

ENGLISH VERSION

REITOX

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INTRODUCTORY NOTE:

Since 2004, the way in which the information contained in the report is presented has changed.

Part A of the report gives information only on new developments which occurred between 2004 and the start of 2005. An introductory paragraph in each section ("general context") summarises the general context and principal characteristics of the section and also provides the framework within which the new information on the drug situation in France is recorded.

Part B, as in previous national reports, contains three articles, each around ten pages long, providing further information on a specific problem linked to illicit drugs.

The report in its entirety covers only the field of illicit drugs (except for the "national policy" and "prevention" sections, which also consider alcohol and tobacco).

In order to have a more accurate view over some specific themes, epidemiological tables and structured questionnaires have been added to this report. Some of these tables are available for France and the whole European countries on the EMCDDA website in the statistical bulletin (<http://statistics.emcdda.eu.int/>).

The report, standard tables and questionnaires are independent of each other but complement each other (see appendix 15.1).

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SUMMARY

Political context 2003-2004

The 2004-2005 year has been mainly marked by the publishing of the national reference document pertaining to risk reduction actions (decree n°2005-347 of April 14th, 2005).

In February 2005 an important media campaign to raise youth awareness upon cannabis damaging effects has been carried out: "Cannabis Is Real". On the whole it can be said that government and media have actually been focused on cannabis for months.

Use

The 2003 ESCAPAD Survey shows for the first time some signs of a slowdown in cannabis use among young males of 17-18 (Beck *et al.*, 2004b, and section 2). Thanks to the same survey, during the 2000-2003 period of time, a slight increase has been observed in some experimentations among the 17-18 year-olds: poppers, ecstasy, amphetamines, and cocaine.

Recent trends

Among recent use tendencies observed in France, a development of hallucinogenic plants has been observed, and more particularly in the recreational area (Bello *et al.*, 2005c, section 4 and the selected issue on "drug use in French recreational areas").

The end of year 2004 and the beginning of 2005 have singled themselves out for intoxication cases due to a cocaine and atropine combination. Twenty-six cases have been recorded, and subjected to a health alert taken over by national press coverage (section 6).

Health, social and legal indicators

For the first time in 2003 cannabis (and its by-products) is the substance bringing about the greatest number of treatments among new patients attending facilities, and ranking just above opiates (Palle *et al.*, 2005, section 4).

The various indicators available validate a decrease in injection practices among drug users (section 4).

"SAM" Survey (Section 6): Results from the Road Safety epidemiological survey on narcotics and fatal road accidents

Carried out by the INRETS (National Institute for Research on Transport and Safety) and coordinated by the OFDT (French Monitoring Centre for Drugs and Drug Addiction) thanks to a DGS (General Health Department) financing, this survey is the first one to enable an accurate evaluation of risks due to cannabis use on driving behaviours.

The 10, 748 exploitable reports of immediately fatal accidents make possible to determine that drivers under the influence of cannabis run 1.8 times more risks to be responsible for a mortal accident than drivers having not used that substance. The over-risk for drivers on alcohol, all alcohol levels taken into account, is comparatively of 8.5 times.

Otherwise the share of fatal accidents due to cannabis positivity registers around 2.5%. All things considered, in France, on a basis of 6,000 mortal accidents, the number attributable to responsibility over-risk relating to driving on cannabis would be around 180 killed individuals. In proportion, these victims are more frequently young males (18-24 years-old) than those dead in an accident involving a responsible driver who has not used cannabis.

The survey also establishes a dose-effect as for alcohol.

In 2004, 69 overdoses have been recorded, a level that proves the lowest one ever reached in France. As we follow up observations made ever since the beginning of years 2000, heroin is less and less causing overdoses unlike psychotropic medicines and cocaine (section 6).

The various legal pointers (arrests, sentences, and incarcerations for drug-law offences) are still on the rise in 2004 (steady increase since year 2002, section 8).

Thirty-one percent of prison entrants' acknowledge an alcohol overuse, and 33% of them a regular and long-lasting illicit drug use during the last twelve months prior to their incarceration (Mouquet, 2005). Meanwhile a survey has been performed on health and social care for prisoners showing some addiction or experiencing an abuse of licit or illicit substances (Obradovic, 2005). That study concludes that even if care is mostly satisfactory in prison, improvements remain to be done in terms of access to substitution treatments and nicotinic substitutes.

Summary of specific indications

Gender differences (F. Beck, S. Chacker et S. Legleye): while Anglo-Saxon countries have developed studies centred on gender and gender approach for a long time in a more wide-ranging way, France proves significantly late in that field. It was not until the eighties that such an issue gradually became obvious in researches, as it focused upon discriminated alcohol uses among males and females. These last years, research teams and contributors (prevention, risk reduction) including that issue in their actions have accounted for a lack of funds granted to that theme, whereas epidemiological data confirm a noticeable difference between genders. The use of licit or illicit psychoactive substances is more a male behaviour; only exceptions to the rule: the use of psychotropic medicines proves mostly female, whereas tobacco addiction has become more and more unisex. Other example: as far as resorting to care is concerned, save for attending tobaccology consultations, males are a lot more present (70 to 80% of the population) than females. [Direct link to the article](#)

European drug policies: extended beyond illicit drugs? (I. Obradovic et C. Diaz Gomez): since 1999, the realm of action of the Interministerial Mission of the Fight against Drug and Drug Addiction (MILDT) has included licit substances, doping, and illicit ones, giving then top priority to use behaviours rather than to substances, and developing the addiction concept. However the principle of extending the drug concept to licit substances has not proved indisputably acquired (e.g.: interventions in the field of prevention, care, or repression, specific status of alcohol and wine in France); that is particularly why the last five-year plan, without reconsidering the legitimacy of a global approach, has chosen to favour an approach per substance. As it coordinates and puts the "drug and drug addiction" programme into action, the plan defined by the MILDT is then taken over by various actors and field contributors (project leaders, CIRDD...). [Direct link to the article](#)

Drug use in French recreational areas: situation in 2004 and recent evolutions (P.-Y. Bello, C. Reynaud-Maurupt, A. Toufik, M. Gandilhon, I. Evrard and the TREND network): thanks to the TREND system, the uses of psychoactive substances occurring in the French techno recreational area have been observed and followed up for some years; regular qualitative surveys have also strengthened that device set up from 1999 onwards. Ever since the end of 2001, a legal framework has been established as far as organizing recreational meetings is concerned, and that has immediately affected the type of events organized, the locations, the attendance, and the substances used in such a context. In the recreational area the most used substances rank as follows: alcohol and tobacco, then cannabis; among illicit substances other than the latter, the use of stimulants and hallucinogens has been increasing these last years. [Direct link to the article](#)

PART A: NEW DEVELOPMENTS AND TRENDS

1. National policy and context

National policy: general context

Legal framework: The law of 31st December 1970 constitutes the legal framework for the French policy on the fight against drugs. It sets 3 principal objectives for public action:

- severe repression of trafficking;
- to establish the principle of prohibiting the use of drugs while at the same time offering treatment as an alternative to suppressing drug use;
- to guarantee free care and anonymity to users who wish to be treated.

The Five-Year Public Health Law for 2004-2008, passed in August 2004, has included the Risk Reduction Policy (RRP) for drug users in Public Health Regulations. So the RRP falls within the competence of government.

The list of products covered by the 1970 law (order of 22nd February 1990 establishing the list of substances classified as drugs) is growing and steadily incorporating new substances recognised as dangerous by order of the Minister of Health, at the proposal of the Director General of the French Health Products Safety Agency (AFSSAPS)¹.

Institutional framework: The interministerial mission to fight against drugs and drug addiction (MILDT) is the authority in charge of preparing the report of the Permanent Interministerial Committee on the fight against drugs and drug addiction and coordinating and implementing decisions which it takes.

The current Chairman of the MILDT, Didier Jayle, was appointed in October 2002. The Five-Year Plan (2004-2008) of action against illicit drugs, tobacco and alcohol has been passed in July 2004 (MILDT, 2004; OFDT, 2004a).

Budget and public expenditure: The main expenditure in terms of fight against drugs is covered by credits from the Ministry of Health and Welfare and from the MILDT. Expenditure for specialised centers for drug addicts (CSST) is covered by health insurance bodies.

Social and cultural context: The great majority of the population believe in the existing measures of the policy for risk reduction (treatment with substitution products, free distribution of syringes) and, overall, continue to support prohibitive measures in relation to drugs (against authorisation under certain conditions of cannabis or heroin use, against free sale of cannabis, (Beck *et al.*, 2003)). Where use of illicit drugs is envisaged for therapeutic purposes under medical supervision, 50% declared themselves in favour of providing heroin and 75% for medical prescription of cannabis to some seriously-ill patients.

In 2002, there were more people in favour of free sale of cannabis than in 1999 but they were still in a minority (24% declared themselves in agreement with this proposal against 17% in 1999).

¹ Appendices I and II to the list of products classified as drugs correspond to tables I and IV in the 1961 International Convention on Drugs. Appendix III includes the substances in Tables I and II and some substances in tables III and IV of the 1971 International Convention on Psychotropic Drugs. Appendix IV contains psychoactive products not classified internationally and some precursors.

1.1 Legal framework

Altering the list of substances registered as narcotics

During the year 2004, by the ministerial order of August 18th, 2004², some modifications have been introduced in annexes III and IV to the list of substances registered as narcotics:

- Annexe III: change in the heading relating amphetamine. "Amphetamine is categorized as narcotic *save for the preparation appearing in tablet form and containing per tablet: amphetamine sulphate 0,005 g, Phenobarbital 0,100 g* ».
- Annexe III: addition of amineptine
- Annexe IV: addition of 2-Cl
- Annexe IV: addition of "*peyotl or peyote, its active principles and their natural and synthetic compounds other than mescaline*".

In 2005, another order³ introduces in annex IV the various substances likely to be included in the contents of Ayahuasca: *Banisteriopsis caapi*, *Peganum harmala*, *Psychotria viridis*, *Diplopterys cabrerana*, *Mimosa hostilis*, *Banisteriopsis rusbyana*, harmine, harmaline, tetrahydroharmine (THH), harmol, harmalol.

Evolution of French legislation on hemp regulation

By Ministerial Order of February 24th, 2004 altering the one of August 22nd, 1990 pertaining to the enforcement of article R. 5181 from Public Health Regulations relating to cannabis (NOR: SANP0420659A, issued in the *Journal Officiel* of March 21st, 2004) French legislation concerning hemp nearly matches European one.

In this new document "*are allowed to be cultivated, imported, exported, as well as industrially and commercially dealt with (fibres and seeds) cannabis sativa types meeting the following standards: the THC delta content of such varieties does not exceed 0.2%*". Determining THC content must operate according to the method of chromatography in gas phase with capillary column.

The Santhica 27 type is added to the list of the 18 varieties authorized for cultivation (against 26 in the European official documents).

Reference document for risk reduction actions

The Decree n°2005-347 of April 14th, 2005 (NOR: SANP0521129D) sets up a national reference document for risk reduction actions directed to drug users, and therefore completes Public Health Regulations. It sets up the CAARUDs (Reception and Risk Reduction Support Centres for Drug Users), and mentions that the latter "*along with all devices contribute to the risk reduction policy*".

This text records in French legislation the goals of risk reduction actions, the modes of intervention, as well as the various activities likely to be operated by structures (distribution of equipment, information about risks...). It also specifies the operative prevention tools and the principles of informing about drug-related risks according to the rule of "*not showing substances in a favourable light*". It also reiterates the significance of health watches and draws a list of possible intervention locations for prevention. That same reference document prohibits *testing* practices (see section 3.1)

² Order of 08/18/2004 (NOR: SANP0422893A) altering the one of 02/22/1990 setting up the list of substances registered as narcotics - *Journal Officiel* of 09/15/2004.

³ Order of 04/20/2005 (NOR: SANP0521544A) altering the one of 02/22/1990 setting up the list of substances registered as narcotics and included in the content of "Ayahuasca" - *Journal Officiel* of 05/03/2005.

1.2 Institutional framework, strategies and policies

Circular letter in order to improve legal response to narcotic use

Following the orientations asserted in the Government Plan of Fight against Illicit Drugs, Tobacco and Alcohol (2004-2008), the Ministry of Justice Circular of April 8th, 2005⁴ has been addressed to prosecutors in order to improve and harmonize the legal response to narcotic use.

It is the most important official document since the Ministry of Justice Circular of June 17th, 1999 which already reformed treatment order procedures, and attempted to remedy the disparity in court proceedings.

This circular letter recommends a “systematic” response to drug users yet also calls for legal actions in magistrate’s courts and incarcerations to remain “exceptional”.

It provides gradual legal responses (call to order, health orientation, care requirement, treatment order) in accordance with the convicts’ use behaviours (“*use exceeding simple experimentation*”, “*hard drug users*” or “*polydrug use*”), the quantity of substance found on them during the report of their offences (regardless of any determined level), or their criminal records. Any legal action before the magistrate’s court must remain exceptional and kept for “recidivists” or “users refusing to submit to alternative measures”. Such procedure shall favour “quick legal action”.

This text requires “*an increasing repression for offences which tends to encourage narcotic use*”. Therefore some behaviours or activities are more specifically aimed at and must be subjected to some legal response:

- “*Hemp shops in which cannabis are sold for home growing*”;
- “*Selling clothes or jewels displaying a cannabis leaf*”;
- “*Distributing publications or review articles praising the virtues of narcotic substances*”;
- “*Selling equipment or accessories along with instructions for dosing narcotics*”.

This circular also recommends being notably aware of offences relating to the organization of rave parties and the misuse of high dose buprenorphine (Subutex®).

Lastly upper limits are provided (varying according to local specificities) below which customs can operate transaction procedures: 20 to 50 grams of cannabis resin, 1 to 5 grams of heroin, 1 to 5 grams of cocaine, and 1 to 5 doses of synthetic drugs.

Warsmann Report for improving the fight against drugs

By the end of June 2004, The Minister of the Interior (who was then M. de Villepin, the current Prime Minister) would regard the fight against drugs as one of the six priority works of the fight against insecurity (OFDT, 2004a, p.13). In order to put such a work into action, the report written by the Member of Parliament, J-L Warsmann, submitted on October 15th, 2004, suggests 44 measures for improving the fight against drugs ((Warsmann, 2004). Structured around solid proposals, the four avenues of work accepted are the following ones:

- Protecting French borders;
- A more efficient dismantling of trafficking groups;
- Seizing financial products from trafficking, and updating the French system of the fight against drug money laundering;
- Developing new indicators of activity for a better assessment of the efficiency of services;

The Minister of the Interior, who was quite pleased about that report, claimed his “*resolve to use that document in order to make the whole French system progress by a great qualitative*

⁴ CRIM 051G4-08042005 ; NOR JUS D 05-30061 C

leap forward". By relying on the Warsmann Report, the Minister of the Interior therefore made no secret of his programme of action for the fight against drugs by the end of 2004. Such a plan is structured around three main axes:

- Intensifying the fight against intermediary trafficking: mainly through a better collaboration and organization among services in charge of such fight;
- Improving the fight against great scale networks: through relying upon a better knowledge of the letter, a development of international cooperation;
- Depriving from trafficking profits those who grow richer at the expense of users: emphasizing the use of "drug immoral earnings" procedure, strengthening the fight against money laundering and the efficiency of methods enabling profits seizure.

1.3 Budget and public expenditure

The Organic Law Pertaining to Finance Laws of August 1st, 2001 (LOLF) deeply reforms state management. It has put gradually into action and will be applicable to the whole French public departments by January 1st, 2006.

From now on the Government global budget is divided into 34 missions, 133 programmes, and about 580 policies, whereas it was defined per ministry in the past.

There is now a "Drugs and Drugs Addiction" programme (within the realm of the Health Mission") which the Chairman of the MILDT is responsible for. For a global development of that plan and its actions, the MILDT will be supported by three operators: the GIP (Public Interest Group) DATIS (National "Drugs, Alcohol, and Tobacco" Telephone Helpline), the GIP OFDT, and the GIP CIFAD (Interministerial Training Centre for the Fight against Drugs). It has also been granted a budget of 38 million euros distributed around three main lines of action:

- Interministerial coordination of the preventive, health care, and repressive areas (67 %⁵) ;
- Experimentation of new partnership devices in prevention, care, and law enforcement (32 %⁵) ;
- International cooperation (1 %⁵).

Chapter 47-11, included in 2003 Finance Law and relating to "public health programmes, prevention and health promotion devices" has then been suppressed in 2004 Finance Law, as well as the various articles have been transferred to Chapter 39-01, "public health and prevention programmes", within the context of experimenting the new organic law.

The interministerial actions of the fight against drug addiction (MILDT Budget) are still being financed through Chapter 47-16 ([Table 1](#)).

1.4 Social and cultural context

During the year 2004-2005, the French media have strongly focused their attentions on cannabis.

Numerous articles and reports have been published in the press following the launching in February 2005 of a large communication campaign, "Cannabis Is Real"⁶, initiated by the Ministry of Solidarities, Health and Family, the MILDT (Interministerial Mission for the Fight

⁵ Indicative data of the 2005 Finance Act.

⁶ Six 25-second promotional films programmed on TV between February 8th and February 27th, eight 35-second ads on teenager radios between February 8th and March 6th, ads in the national daily papers, setting up of a specific telephone helpline, "Écoute Cannabis", as well as distribution of information booklets among teenagers and their parents.

Against Drugs and Drug Addiction), and the INPES (National Institute for Health, Education, and Prevention), as well as the setting up of evaluation and support consultations for users.

Le Figaro, one of the major French dailies, ran a “Cannabis, State of Alert” headline in its February 2nd issue, while *Le Monde*, a reference paper, dealt with the “Cannabis and Pedagogy” theme in its leading article on February 3rd. During the following weeks other pieces of writing took over in general-interest weeklies (notably the *Nouvel Observateur* front cover of February 17th: “Teenagers and Cannabis: A Survey on the Dangers of a Drug Not as Soft as It Seems”, followed by an 8-page special report), women’s magazines, and health periodicals.

Generally speaking there is a sustained interest in teenagers’ use of psychoactive substances. This can be particularly proved by the results taken up from the 2003 ESCAPAD Survey, as well as the articles relating to the local exploitation of that study which enables discriminating the profiles of the various French regions in July 2005.

All through that period a follow-up of the articles on road safety and the use of psychoactive substances, notably cannabis, can also be noticed. The issue on screening and setting up saliva tests has therefore been dealt with regularly: in October 2004 by the Agence France Presse, *Le Figaro*, and *Libération*, then in the end of January by *Le Figaro* and *Le Parisien*.

Among other subjects having caught the attention of the press during 2004-2005 stands the issue on crack use and Parisian Region users. In September 2004 numerous articles (AFP, as well as in *Le Parisien*, *L’Humanité*, *Libération*, *Le Monde*, and *La Croix*) commented on the eviction of about 126 squatters using crack in the Seine Saint-Denis département, before another squat expulsion taking place in November in the North of Paris. Each time journalists would insist on these users’ wandering and helplessness. In June 2005, while a convention on crack has been organized by the Council of Paris 18th District, the damages caused by the use of such substance in the North-Eastern part of the capital and Seine Saint-Denis have once again been evoked in *Le Parisien* and *Libération*, whose headline of its June 18th issue reads as follows: “When Paris is Cracking Up Against Crack”.

Lastly from December 2004 onwards and especially in January 2005 a series of articles and dispatches (AFP and Reuters) can be added up, as they have dealt with cases of intoxication subsequent to a sniffed or injected use of a cocaine combination containing atropine. “Watch out for cocaine fatal cocktail” is the headline of *Le Parisien* January 13th issue, while France Soir points out: “Watch Out for Cocaine-Atropine” on the same day. As their counterparts, these papers have insisted on one of the contents of such combination called “crystalline”.

Table 1: Specific funds devoted to interministerial actions of the fight against drug addiction, granted by Finance Act and allocated, 2002-2004

Specific funds granted by the initial Finance Act	2002	2003	2004
Chapter 47-16: interministerial actions of the fight against drug addiction	45.58	40.05	38.04
Budget actually allocated			
47-16 article 10 (funds transferred to Ministries)	5.69	6.39	3.90
47-16 article 20 (decentralized intervention funds)	14.15	15.11	10.35
47-16 article 30 (decentralized funds, prevention programme, CDO, CIRDD)	21.47	16.01	19.50
Total ⁽¹⁾	41.31	37.51	33.75

(1) The disparity between allocated funds and actual ones is mostly due to budget freezes having occurred during the year.

Sources: MILDT; Treasury special accounts (“les Verts”), Ministry of Economy, Finance and Industry.

2. Drug use in the population

Drug use in the population: general context

Drug use is generally classified on four levels which relate to the extent of use; these levels have been established on the basis of indicators used internationally:

- experimentation: having used the product at least once;
- occasional use: use at least once a year;
- regular use: use at least 10 times in the last 30 days;
- daily use: use every day.

In some cases, recent use (use at least once in the last 30 days) is also used.

Drug use among the general population: there are several surveys in France which collect data on this subject:

- for the adult population: the Health Barometer (Institut national de prévention et d'éducation pour la santé –INPES- National Institute for Health Education and Prevention), survey every four years); survey on Representations, Opinions and Perceptions regarding Psychotropic Drugs (EROPP) carried out every 3 years by OFDT [Standard table no. 1].
- for the school population: European School survey project on alcohol and other drugs (ESPAD) carried out every 4 years (INSERM-OFDT) [Standard table no. 2].
- for young people: annual survey on health and consumption on call-up and preparation for defence day (ESCAPAD) carried out by the OFDT among young people aged from 17 to 19. This survey in particular is an opportunity to question young people who have left school early [Standard table no. 30].

Cannabis is the illicit substance most used in France and its use has increased significantly over the last 10 years. In 2002, 2 out of 5 adults had already experimented with cannabis and fewer than 1 out of 10 used it occasionally or regularly (Beck *et al.*, 2003).

Cannabis use mostly concerns all social circles even though some slight differences may be observed. This substance appears to be a little more used by pupils and students (Beck *et al.*, 2005a), bachelors (Beck *et al.*, 2002), unemployed individuals, and, among working ones, by intermediate jobholders, yet notably less used by workers (Legleye and Beck, 2004); however most differences between socio-professional categories do not stand out.

Besides cannabis, acknowledged drug experimentations remain minor: e.g. there are 10.9 millions individuals experimenting cannabis, 1 million for cocaine, 500,000 for ecstasy, or even 400,000 for heroin (Beck *et al.*, 2004a). However, the slight increase in levels of experimentation among the 18-44 year-olds for cocaine (3.3% compared to 1.6%), hallucinogens (3.0% compared to 2.4%), ecstasy or amphetamines (2.5% compared to 1.2%) between 1995 and 2002 demonstrate that use of these products is spreading. The level of experimentation with heroin itself has been stable for around ten years (Beck and Legleye, 2003b).

Whatever the product considered, men living in large cities are more likely to experiment (Beck *et al.*, 2002). Experimenters with illicit drugs are frequently unemployed or living with poor material resources, with the notable exception of experimenters with cannabis, who are better integrated socially.

At the age of 17, after tobacco, alcohol and cannabis (54.6% of boys and 45.7% of girls) and psychotropic medicines, the products most experimented with are inhalants (5.2%), hallucinogenic mushrooms (4.2%), poppers (4.0%), ecstasy (3.9%) and, to a lesser extent, amphetamines (2.0%), cocaine (1.6%) and LSD (1.3%) (according to ESCAPAD 2002, , (Beck and Legleye, 2003a)).

Drug use among specific groups: the latest investigations carried out among people working as prostitutes (men and transsexuals, women) show that recent use of illicit drugs, excluding cannabis, involves a minority (Cagliero and Lagrange, 2004; Da Silva, 2003). However it

appears to be more frequent among men and transsexuals (recent use of poppers 13%, 11% for ecstasy, 7% for cocaine, 2% for heroin) than among women (recent use of heroin 5%).

Among the homeless the data is patchy, but it is known that all products are available and are used. Users living on the street "have addiction practices which are noticeably different from those of addicts who are better socially integrated: when you have no money or plans, you use what you can get on the day [...]" (Solal and Schneider, 1996). Estimates of the prevalence of use of illicit drugs in the last few months vary from 10% to 21% or even 30% depending on age, income level, the cause of their being on the street and the aid facilities attended (Amosse *et al.*, 2001; Kovess and Mangin Lazarus, 1997; Observatoire du Samu social de Paris, 1999). The most-used drugs, apart from alcohol and tobacco, are cannabis and cocaine.

Although collection of epidemiological data on drug addicts among professionals is hindered by obstacles of various types (ethical, technical, financial, time, regulatory, cultural, practical), some assessment information is available. In 1995, a study of anonymous urine samples given by 1,976 employees from the Nord Pas de Calais found that 17.5% of workers used at least one psychoactive substance and in jobs relating to safety and security the figure was 40% of workers (Fontaine, 2002b). For the majority of users in the professions, use is hidden from their professional circle; work time and use time are as far as possible kept separate (Fontaine, 2002a).

Attitudes to drugs and drug users: the tool used to evaluate the attitudes of French people to drugs and drug users is the EROPP survey. This survey helps to measure the level of information there is about drugs, substances known as drugs, and the estimated degree of danger of the products. The study also looks at the representations of drug addiction in public opinion.

In 2002, 61% of French people stated that they felt they were well-informed about drugs, which was slightly more than in 1999. In response to the question: "What are the main drugs you are aware of and do you know their names?", the French cited on average 3.8 products. The product the most often cited was cannabis (82%), followed by cocaine (60%), heroin (48%) then ecstasy (37%) (Beck *et al.*, 2003).

The product considered most dangerous by French people is heroin, well ahead of ecstasy and cocaine, alcohol and tobacco and finally cannabis (only 2% of those questioned felt that cannabis is the most dangerous product). This classification does not vary much with age, sex or socio-professional category. The perceived danger of cannabis varies with age and sex and, particularly, depending on familiarity with the product (Beck *et al.*, 2003).

2.1 Drug use in the general population

New estimate of the number of users of psychoactive substances in France

The new ESCAPAD Survey of 2003 (See *next subsection*) has made possible an update of the estimate of the amount of French individuals concerned by the various uses of psychoactive substances. These figures stand for rough approximations and must be regarded as guidelines (Beck *et al.*, 2004b) ([Table 2](#)).

2.2 Drug use among young people and school children

17 to 18 teenagers

2000-2003 Evolutions

The ESCAPAD Survey carried out in 2003 focuses on a sample of 21,151 teenagers of 17-18 (spread over Metropolitan France, French overseas départements and Pacific territories). The sample used for exploitation includes 7,473 boys and 7,575 girls, that is to say a total of 15,048 of 17 and 18 year-olds. At the time of the survey, a majority of the latter would declare themselves students (87% of the 17 year-olds, 84% of the 18 year-olds), the girls more often than the boys; they mostly live at their parents' (88%).

Table 2: Estimate of the number of individuals using psychoactive substances in Metropolitan France among the 12-75 year-olds, 2003

	Alcohol	Tobacco	Psychotropic medicines	Cannabis	Cocaine	Ecstasy	Heroin
Experimenters ⁽¹⁾	44.4 M	36.6 M	//	10.9 M	1.0 M	500 000	400 000
Occasional users ⁽²⁾	41.8 M	16.0 M	8.9 M	4.2 M	200 000	200 000	//
Regular users ⁽³⁾	13.1 M	13.0 M	3.8 M	850 000	//	//	//
Daily users ⁽⁴⁾	7.8 M	13.0 M	2.4 M	450 000	//	//	//

M: millions. //: unavailable.

(1) individuals declaring having used a substance at least once in their lifetimes; (2) individuals having used a substance during the year (apart from tobacco: current smokers); (3) at least 3 weekly alcohol uses, daily tobacco use, weekly use of sleeping pills or tranquillizers, 10 monthly cannabis uses; (4) daily use (except for medicines: daily or near-daily use during the month).

NB: in 2001 the number of 12-75 year-olds is close to 46 millions.

Sources: 2003 ESCAPAD, OFDT; 2003 ESPAD, INSERM/OFTD/MJENR; 2002 EROPP, OFDT; 2000 Baromètre Santé, INPES, OFDT operating.

As far as illicit drugs are concerned, the results from the 2003 Survey show the following trends (Beck *et al.*, 2004a; Beck *et al.*, 2004b) (Table 3):

- Cannabis lifetime and recent uses have increased among girls as well as among boys throughout the 2000-2003 period of time. But signs of a slowdown have been observed between 2002 and 2003 among boys (beginnings of a decrease in experimentation). Such a drop is occurring as France has been ranking first among European countries for cannabis experimentation since late nineties;
- A slight increase in some experimentations between 2000 and 2003: poppers, ecstasy, amphetamines and cocaine;
- As for the experimentation levels of inhalants, hallucinogenic mushrooms, LSD, heroin, and crack, they have not changed since 2000.

In 2003 the recent uses of illicit substances other than cannabis among 17-18 year-olds remain extremely infrequent. Only ecstasy exceeds 1%.

This ESCAPAD Survey enables an update on the experimentation levels of ketamine, Subutex® and GHB, which were not surveyed in previous years. Among the 17-18 year-olds, the levels of lifetime uses prove quite low for those substances, respectively: 0.3%, 0.6%, and 0.3%.

Uses according to school and work status

The ESCAPAD Survey allows to highlight and quantify the differences of levels of use among the major psychoactive substances, according to the 17-18 year-olds' school or work status (Beck *et al.*, 2004b).

A majority of students surveyed are attending school or university (84.8%), some of them following a block-release training (11.6%), while others have more uncommonly dropped out of the school system (3.6%). When it comes to school pupils, we can know when they have possibly repeated a year, or which courses they have enrolled in.

A descriptive analysis of the differences in cannabis use according to school status shows that teenagers enlisted in standard courses generally reveal lower levels of use when compared with those enrolled in vocational courses (Table 4). Youngsters out of the school system, working or unemployed register the highest cannabis levels of use when compared with the other two categories.

Repeating one's year in the standard education course proves closely connected with the uses of tobacco, alcohol and cannabis. As far as cannabis regular use is concerned, the connection stands clearly out: 7.3% among pupils who have not repeated their years, 14% among those having repeated once, and 13.4% among those having repeated twice or more

($p < 0,001$). On the other hand, such a connection cannot be observed among pupils attending vocational training courses.

Table 3: 2000-2003 Lifetime use evolution of psychoactive substances by gender at 17 (% on lines)

	Girls 2000	Girls 2003	Boys 2000	Boys 2003	Both 2000	Both 2003
Alcohol	-	94.2	-	95.0	-	94.6
Tobacco	79.4	79.0	76.0	75.0	77.7	77.0
Drunkenness	49.5	47.6	63.3	62.2	56.4	55.0
Cannabis	40.1	47.2***	50.1	53.3**	45.5	50.3***
Psychotropic medicines	29.0	35.5***	10.6	14.3***	19.8	24.7***
Inhalants	3.3	4.0	4.9	4.7	4.1	4.4
Hallucinogenic mushrooms	1.6	2.0	4.5	4.9	3.1	3.5
Poppers	1.3	2.4***	3.4	4.1	2.4	3.3***
Ecstasy	1.4	2.4**	2.8	4.1***	2.1	3.2***
Amphetamines	0.6	1.1*	1.4	2.4***	1.0	1.8***
Cocaine	0.6	1.1*	1.3	2.0	1.0	1.6***
LSD	0.8	0.6	1.6*	1.1	1.2	0.9
Heroin	0.4	0.7	0.9	1.0	0.7	0.8
Crack	0.2	0.5	0.9	0.6	0.6	0.6
Subutex®	-	0.4	-	0.9	-	0.6
Ketamine	-	0.2	-	0.5	-	0.3
GHB	-	0.3	-	0.3	-	-

Reading: *, **, ***: 2000-03 evolution significant at the 0.05, 0.01, 0.001 thresholds; non-asterisk ratios describe irrelevant evolutions at the 0.05 threshold. Ratios in block letters point to significantly higher prevalences.

Source: 2003 ESCAPAD Survey, OFDT.

Table 4: 2003 Cannabis regular uses among 17-18 year-olds, according to age and school status (ratios lined up)

	17	18	17-18
Standard education			
<i>Vocational</i>	13.3	16.1	14.7
<i>General</i>	8.5	12.0	10.2
Both	9.9***	13.3***	11.6***
Apprenticeship/block-release training (CAP, BEP)	15.2	21.8	18.7
Out of school (unemployed, working)	16.3	27.5	24.1

*, **, ***: Chi-square two sample test for the difference between school status respectively significant at the thresholds of 0.05, 0.01, and 0.001.

Reading: cannabis regular use concerns 9.9% of the whole teenagers attending schools, such a disparity being significant at the 0.001 threshold between both courses (vocational and general).

Source: ESCAPAD 2003, OFDT.

Cannabis contexts of use

There is a great diversity of cannabis modes of use, from simple experimentation never repeated to daily and significant uses, yet a majority of them seem to fall within the scope of controlled practices. The data collected during the survey enable to establish that the

weekend stands for the special moment of use, and that during such a period uses prove the most intense ones: among the individuals having used during the previous month, more than 9 out of ten acknowledge smoking at the weekend against 7 out of 10 during weekdays. The survey also brings to light the connection between use frequency and intensity: nearly three-quarters of daily users declare smoking usually at least 5 joints a day at the weekend, against 3 daily users out of 10 when using. During their last uses (on the day prior to the survey) about one daily user out of five declares having smoked one joint at most, one third of them admit two or three joints, and more than one third acknowledge five joints at least. However the survey cannot allow indicating if such joints are smoked lonely or shared.

According to the CAST (Cannabis Abuse Screening Test) unit created at the OFDT (See *2002 ESCAPAD Report*) and brought in the survey (OFDT, 2004a, p. 33 in order to see the detailed test), 14% of the 17-18 year-olds would show signs of a high risk of problematic use (9% of girls, and 18% of boys), while 6% of them would be experiencing a regular use with a slighter risk to drift onto a challenging use. The teenagers concerned by such signs of problematic use differentiate themselves from others by a little more difficulties at school and more significant care uses in the realm of psychological health. On the other hand there are very small disparities as far as social origins are concerned: in the survey the youth coming from the least fortunate families are no more affected than those belonging to the most favoured ones. On the contrary, among teenagers spotted out as presenting some risk of challenging use, the share of those coming from humble families (whose parents are workers, employees, or without any occupation) ranks a bit lower than average, especially among boys.

Influence of cannabis precocious use

This side analysis does not aim at explaining recent uses according to past one or events from personal backgrounds, but rather at painting a picture of factors relating to uses and relocating precociousness within these factors. Having smoked cannabis at an early age stands for the behaviour most commonly associated with current use, as far as its frequency, intensity or problematic characteristics are concerned. The second factor is the use of cannabis by peers: other things being equal, claiming that most of one's friends are users proves quite connected with a regular use. On the other hand family status (parents' separation, living in a non-parental home) does not seem to carry weight in it.

Cannabis purchase

New questions brought in the survey questionnaire enable for the first time an estimate of the money spent by 17-18 year-olds for purchasing cannabis during the weeks prior to the survey, whose amounts may be compared with the incomes declared (pocket money, salary, other resources). Boys, who stand for more frequent users than girls, also acknowledge higher expenditures, even when frequencies of use are comparable.

The monthly amounts spent for cannabis vary from € 27 for users during the month to € 54 for regular users, and exceed € 80 for daily users. When it comes to the latter their cannabis "budget" stands for an average 33% of their incomes (pocket money, salary, and other resources).

According to the assumptions accepted, the amounts of money spent monthly by the whole 17-18 years-old French in 2003 for cannabis purchase would rank between 12 and 21 million Euros (M€). When adding up to that the sums spent for alcohol and tobacco, and considering the average of low and high estimates, the French of 17-18 would spend a monthly sum close to M€ 94 for their use of these three substances.

Regional exploitations of the ESCAPAD Survey

Regional atlas

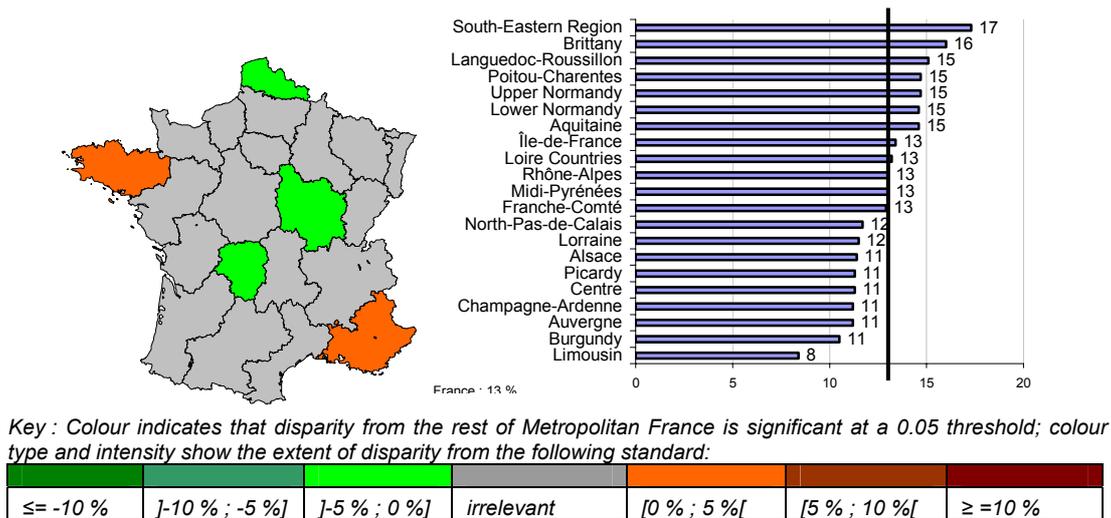
As far as teenagers' use is concerned, a systematic regional analysis of the data collected by the 2002-2003 ESCAPAD Survey has been carried out. Such exploitation enables drawing a

map of Metropolitan uses (save for Corsica) as well as those of overseas départements and Pacific territories (Réunion, Guadeloupe, Martinique, French Guiana, New Caledonia, French Polynesia).

The sample exploited amounts to 27,354 teenagers of 17 for Metropolitan France (14,515 in 2002 and 12,839 in 2003), and 3,955 for the DOMs and COMs.

Cannabis users prove quite identical over the whole French Metropolitan territory. Regular use is more widespread in Brittany and in the Mediterranean region. Conversely it appears more infrequent in North-Pas-de-Calais, Burgundy, and Limousin.

Figure 1: Cannabis regular use at 17



Source: 2002/2003 ESCAPAD Survey, OFDT, regional exploitation.

Concerning other illicit substances, experimentation figures appear roughly similar on French territory apart from ecstasy (more often experimented in North-Pas-de-Calais, Franche-Comté, Languedoc-Roussillon), cocaine (whose experimentation proves more frequent in the Mediterranean region), and to a lesser extent LSD (whose experimentation is more widespread in Languedoc-Roussillon, Provence-Alpes-Côte d'Azur, and Brittany).

In the DOMs, cannabis uses are more infrequent than in Metropolitan France, as well as for the experimentation of other illicit substances. In the COMs cannabis users are similar to those from the DOMs; on the other hand the experimentations of inhalants, LSD, cocaine, amphetamines, ecstasy or heroine is closer are closer to those measured in Metropolitan France (Beck *et al.*, 2005b; Beck *et al.*, 2005c).

Teenagers' drug uses in Île-de-France

The exploitation of the ESCAPAD Survey for Île-de-France⁷ relates to data collected in 2002-2003: 2,484 teenagers of 17 (1,240 boys and 1,244 girls; 90% of them are pupils or students).

As a rule, prevalences observed in Île-de-France among teenagers rank lower than those measured in the rest of the country (regular uses of tobacco and alcohol, drunkenness experimentation, regular drunkenness). When it comes to cannabis use, the rates from Île-de-France are closer to those from the rest of the country. The only substances for which experimentation appears more frequent in Île-de-France are psychotropic medicines (for boys only), poppers and crack (for boys only). Concerning all other substances,

⁷ Île-de-France includes the city of Paris (capital) and the seven surrounding départements. It is the most densely populated French region with 11 million inhabitants, namely 18% of the French population. It is a young and working region: 32% of its inhabitants are under 25 years old, and only 17% of them are 60 and over.

experimentation prevalences are lower or similar to those found in the whole of other French regions (Beck *et al.*, 2004c ; Beck *et al.*, 2005d).

Table 5: Comparison of psychoactive substances experimented at 17 in Île-de-France and other French regions, by gender (ratios), 2002-2003

	Boys		Girls	
	Île-de-France	Other regions	Île-de-France	Other regions
Alcohol	90.0***	94.8	89.8***	93.8
Tobacco	73.4***	76.6	76.5***	79.7
Cannabis	58.6	57.1	46.7*	48.9
Drunkenness	51.1***	64.2	38.6***	49.3
Poppers	17.0***	14.1	36.9	35.1
Medicines	6.9***	5.2	4.3*	3.5
Hallucinogenic mushrooms	4.5***	6.1	2.9	2.4
Ecstasy	4.5	5.3	2.7	3.1
Inhalants	4.6**	6.3	2.5***	4.5
Amphetamines	1.9**	2.9	1.0*	1.6
LSD	1.8	1.8	0.8	0.9
Crack	1.4*	0.9	0.4	0.5
Cocaine	2.1	2.5	1.1	1.4
Heroin	1.1	1.2	0.2	0.7

Assessment: *, **, *** point to disparities respectively significant at the thresholds of 0.05, 0.01, and 0.001 between Île-de-France and other French regions. Significantly higher prevalences appear in block letters.

Source: 2002/2003 ESCAPAD Survey, OFDT, Île-de-France exploitation.

2.3 Drug use among specific groups

Addictive behaviours among army volunteers

A transversal study has been performed between 1999 and 2002 among French army volunteers stationed overseas, in order to estimate the prevalence of addictive behaviours among that population, and measure the influence of overseas stationing upon uses. A little more than 1,000 individuals have been surveyed and urinary samples have been systematically taken.

Cannabis represents the most frequently experimented drug (44% of subjects), then ecstasy (6.4%), cocaine (4.5%), other drugs or medicines (2.3%), and opiates (heroin and morphine, 1.1%). Urinary tests have brought into light the presence of cannabis (9.1% of urinary samples), amphetamines (1.1% of samples), and cocaine (0.4% of samples) among army volunteers.

When compared with the general population⁸ the uses of cannabis and heroine are similar, whereas the experimentations of cocaine (4.5% vs. 2.2/2.5%) and ecstasy (6.4 vs. 0.9/2.8%) are more frequent among army volunteers. Staying overseas seems associated with an increase in the uses (+1.3% for illicit drugs) yet many factors may be accounted for (Mancini *et al.*, 2004).

⁸ Data from that survey have been compared to those from Baromètre santé 2000.

Use of substances in gay and lesbian recreational areas

In autumn of 2003 out of 14,000 questionnaires distributed around 43 Parisian recreational venues (among which 4 were “females only” locations) 3,500 have been collected, of which about 2,800 have been exploited and therefore enabled a better knowledge of uses among such a gay and lesbian attendance.

The majority of individuals having responded are males (80%), of which 85% acknowledge being gay, 8% bisexual, and 4% heterosexual. When it comes to females, 20% of them are heterosexual, 11% bisexual, and 62% admit being lesbians. 88% of respondents rank between 18 and 39 years-old; 61% are single; 65% live inside Paris.

In a party, gays and lesbians do not drink more alcohol than the average of French individuals; they smoke less cannabis (19%) yet sniff more poppers (10% on a regular basis, 30% occasionally or rarely) and cocaine. The uses of ketamine or GHB remain insignificant.

The frequencies of use are “*systematically decreasing when substances are taken before a sexual intercourse, likely to reveal there is no psychotropic intake specifically associated with sex*” and that running risks (e.g.: unsafe sex) does not result from the possible effects of substances but from a deliberate abnormal behaviour (Le Kiosque *et al.*, 2005).

2.4 Attitudes to drugs and users

NO NEW INFORMATION AVAILABLE

3. Prevention

Prevention: general context

(For more details, see the 2004 National Report)

Legislation framework:

French legislation does not cover the field of drug prevention. The founding law pertaining to the fight against drugs – December 31st, 1970 Law n°70-1320 – does not tackle it. As such, the only laws making exceptions to it are the one known as the “Evin” Law of January 10th, 1991⁹ – regulating alcohol and tobacco use in public places as well as advertising them –, and the circular letters from the Ministry of National Education supporting the prevention of risk behaviours since 1990.

The scope of the French risk prevention policy is presently defined by two main official texts which set up the principle of harmonizing and generalizing prevention via some planning throughout school years, from primary education onwards and notably during secondary one:

- The 2004-2008 Government Plan of Fight Against Illicit Drugs, Tobacco and Alcohol, which, as far as prevention is concerned, particularly emphasizes cannabis, tobacco and school, as it intends to set up the necessary conditions of an actual prevention that would match all education levels;

- The 2003-2008 Five-Year Program of Prevention and Education developed by the Ministry of National Education¹⁰.

The 2003-2008 National Plan of Fight Against Cancer may also be accounted for - as it has raised a real fervour and funds for actions against tobacco – as well as the Five-Year Public Health Law of August 9th, 2004, which establishes at least one yearly session of prevention in secondary schools, and, among other things, determines the goals for cutting down passive tobacco exposure at school, in recreational areas, and at work.

Political coordination, from central down to local level:

Ever since 1999 the fight against drugs has been extended to legal psychoactive substances like alcohol, tobacco, and psychotropic medicines. It supports two strong principles: an early intervention among youngsters in order to delay the age of use initiation, and an intervention that does not only aim at preventing use but also at restricting abuses.

Boosting and coordinating prevention policies come under the authority of the MILDT. National orientations are described in the Government Plan which MILDT represents. In each ministry concerned, a department coordinates the goals of prevention between central and local levels, as well as it handles the subject with the MILDT.

Bringing national orientations down to local levels therefore depends on decentralized government services but also on the specific system of the “drug” policy coordinated by the MILDT. The latter is notably based on the appointment of a “drugs and drug addiction” project leader in each French - from the body of prefects -, and a coordinator issuing from decentralized services¹¹. The project leader defines and organizes prevention policy in his/her département. For that purpose (s)he has funds devoted to the prevention of addictions and the training of professionals, as well as (s)he seeks advice from local institutions (government services, legal authorities, territorial bodies¹², and as far as possible major associations) in order to coordinate the goals of public contributors and determine financing.

⁹ Law n°91-32 of January 10th, 1991 pertaining to the fight against tobacco and alcohol addictions, *Journal Officiel*, January 12th 1991, p. 4148 (NOR : SPSX9000097L)

¹⁰ Set up by the Circular Letter n°2003-210 of December 11th, 2003; NOR: MENE0302706C.

¹¹ The two-person team has been set up since 2004. Project leaders located in regional capital cities operate a regional coordination especially for medical care.

¹² Decentralized public services of a département or a region, self-governing and having their own competences in such areas as health, child social support or child care.

In schools, headmasters set up yearly prevention measures to be conducted among pupils. While they are allowed some freedom of movement, they are nevertheless given some education authority recommendations issuing from ministerial orientations. Most of secondary schools have a *Comité d'éducation à la santé et à la citoyenneté* (CESC, Health and Citizenship Education Committee) gathering the education community and outside contributors (associations, institutional contributors, etc.) in order to coordinate prevention within their own schools.

Institutional and administrative framework for the prevention of addictions:

Drug prevention has always fallen within a process of extending the common rights and services granted by government or delegated to associations, according to a local community principle (decision-making levels and local contributors).

Locating priority intervention areas (ZUS or ZEP¹³), in accordance with socioeconomic indicators referring to accommodation or education quality (rate of school backwardness and rate of scholarship holders), enables gathering additional funds for underprivileged populations.

Territorial and trans-sectional coordination devices make possible a coherent distribution of public funds. They fall within the scope of the fight against drugs or health and social exclusion (PRSP), law and order or local authority policies (CLS, CEL)¹⁴.

There are as many financing sources as professional bodies involved in prevention. In the state sector only services in charge of law enforcement train experts likely to meet young or grown-up populations, on request of schools or other services: they are the FRAD (*Formateurs relais antidrogue de la gendarmerie nationale*; Anti-drug shift trainers belonging to the National Gendarmerie) and the PFAD (*policiers formateurs antidrogue*, police officers in charge of anti-drug training).

Supporting decision-making and professional networks:

The National Institute for Health, Education and Prevention (INPES) is commissioned to carry out an expert appraisal, develop prevention practices, and set up national programmes (in particular media campaigns). Other bodies may support professionals specialised or not in the realm of drug prevention:

- The regional centres for information and resources on drugs and dependencies (CIRDD), standing as a technical support for drugs and dependencies project managers (CPDD), and public services, through their duties including research, methodology guidance for developing projects, and observation, notably in the field of prevention. A revision of such a device is under way;
- The drug addiction information network called « Toxibase », which also manages a section on French-speaking tools pertaining to various prevention themes;
- The prevention tools validation committee, coordinated by the MILDT, which delivers a qualitative opinion on the tools submitted to it, in order to favour the reliability and consistence of the views expressed.

In order to be represented in public debates and to promote professional exchanges, specialised contributors belonging to associations are gathered in federations: FNES, ANPAA,

¹³ ZUS: *Zones urbaines sensibles* (Sensitive Urban Areas); ZEP: *Zones d'éducation prioritaires* (Priority Education Areas).

¹⁴ PRSP: the *Programmes régionaux de santé publique* (Regional Public Health Programmes) take over from the *Programmes régionaux de santé* (PRS; Regional Health Programmes) and the *Programmes régionaux d'accès à la prévention et aux soins pour les personnes en situation de précarité* (PRAPS; Programmes for Access to Preventive Measures and Health Care for People in Vulnerable Situations); CLS: *Contrats locaux de sécurité* (Local Security Contracts); CEL: *Contrats éducatifs locaux* (Local Educational Contracts).

ANIT FFA, CRIPS¹⁵. All these associations set up training courses, lectures, think-tanks, or information networks connected with preventing the use of psychoactive substances.

Some references on French prevention devices:

Most prevention actions pertaining to addictions operate in schools and widely involve the education community in coordination as well as in acting. The “selective” or “indicated” prevention is mainly issuing from specialised contributors belonging to associations (see: “cannabis consultations”, section 3.2), but also from services under local or even département authority, as their scope of activities covers child social support or child care. It is worth noticing that such terms as “selective” or “indicated” prevention are not used in France.

See also [Structured questionnaire no. 22] on universal school based prevention and [Structured questionnaire no.] on

In practical terms, drug prevention is characterized by a slight interventionist government policy. Up till now there has been no pattern forced neither on professional networks nor on institutions, yet this might evolve in a near future, through the political will to plan prevention at school. However thanks to various initiatives developed in order to professionalize such a field, harmonize the action principles, some approaches are coming up: going beyond the information on risks; interaction; developing psychosocial expertise... Yet the *modus operandi* of such expertise remains vague for many contributors.

National permanent prevention devices will follow:

- The *Drogues Alcool Tabac Info Service* national telephone helpline (DATIS, “Drugs, Alcohol, and Tobacco Information Service”);
- The information and prevention touring campaign on drug addiction, managed by the *Mission de lutte anti-drogue* (MILAD, Mission for the Fight Against Drugs; Ministry of the Interior) which visits numerous schools and the French coastline during summer;
- The *Points Écoute* (Reception Centres), support, orientation and arbitration facilities for the youth and/or their parents, in tune with challenging drug uses;
- The Youth Reception and Counselling Centres (*Points d'accueil et d'écoute jeunes*, PAEJ), less specialised yet devoted to youngsters experiencing high-risk situations (poverty, wandering) and the people around them, within the realm of the fight against social exclusion.

Monitoring prevention today:

Despite some attempts France is not granted an effective monitoring system for prevention. Yet this field obviously lacks clarity because of the multiplicity of the contributors’ information systems and funding.

Today such a situation puts a brake on any attempts to make an accurate national inventory on French prevention. It accounts for the prevalence of support and help facilities in the national strategies described in this report.

3.1 Universal prevention

National prevention policy at school

Both government plan and the Ministry of National Education Prevention and Education Programme for 2003-2008 have set up a national programming for prevention policy at school. In that perspective, the MILDT and the aforementioned ministry, helped by numerous institutional partners, have developed an intervention manual for preventing addictive behaviours at school. In February 2005 that brochure has been distributed in around 80

¹⁵ FNES: *Fédération nationale des comités d'éducation pour la santé* (National Federation of Health Education Committees; www.fnes.info); ANPAA: *Association nationale de prévention en alcoologie et addictologie* (set up in 1872, National Association for the Prevention of Alcoholism and Addiction, www.anpaa.asso.fr); ANIT: *Association nationale des intervenants en toxicomanie* (National Association of Drug Addiction Workers, www.anit.asso.fr); FFA: *Fédération française d'addictologie* (French Federation of Addictology, www.addictologie.org); CRIPS: *Centres régionaux d'information et de prévention du sida*, (Network of Regional Information and AIDS Information Centres, www.lecrips.net/reseau.htm).

schools on a trial basis, for its writers to be able to value its applicability, improve and complete it with a view to spread its diffusion by autumn 2006.

In its experimental form that document specifies the institutional and technical means supplied to schools, as well as it outlines the psycho-affective development among children and teenagers, the various uses around France, the present legislation, and suggests:

- A 4-session intervention plan for pupils attending CM2 and 6ième¹⁶ (11-12 years-old pupils on average) particularly focused on tobacco ;
- A 4-session intervention plan for pupils attending 3ième and 2nde¹⁷ (15-16 years-old pupils on average) particularly focused on cannabis.

This guide has yet to be completed with intervention units on alcohol and ecstasy.

Global intervention directed to communities

From January 2005 onwards more than 250 “cannabis” consultations, announced by the government plan, have been set up all around the French territory. Devoted to teenagers with difficulties on account of their uses of cannabis or other drugs, as well as to their parents, such reception and support facilities are anonymous and free. They are located in the major French cities in order to be easy to get to. Consultations are performed by professionals trained to using evaluation tools and quick interventions within the realm of addictions, as well as able to detect social, medical or psychiatric services adapted to patients needing specialised care. This new type of structure is submitted to a follow-up (results to come by the first quarter of 2006). The first data available for the activities of these consultations show that two or three months after that device has been set up about 3,500 and 4,000 individuals per month have attended such facilities, among whom 2,000 to 2,500 cannabis users (the others being parents, relatives, youth workers...) (OFDT, 2005c).

Recreational area

A national reference document for risk reduction actions relating to drug uses has been passed by ministerial order on April 14th, 2005¹⁸. From that date onwards *testing* practices are banned, as they do not enable a “*detection of substances included in the contents of tablets*”, in accordance with what has been established by the government plan of the fight against drugs. Prevention actions in the recreational area should conform to that intervention reference document.

Telephone helpline

In 2004 a new telephone helpline has been set up: “Écoute cannabis”. The decreasing amount of calls answered by the DATIS helpline against 2003 figures (625,000 vs. 800,000 in 2003) can be essentially explained by the change of telephone number (from 113 to 08231313 still toll-free). Among those calls 12% of them have a *request* (that is identified by the service as actual requests). Users (54%) as their friends or family (36%) or professionals make use of this device. During calls licit substances have been quoted in 64% of cases. Among illicit substances (36% of calls), cannabis remain the substance most frequently mentioned (25% of all *request* calls; following alcohol yet ranking before tobacco), far ahead of heroin (5% of *request* calls with a content), cocaine (4% of *request* calls) or ecstasy (3% of *request* calls).

¹⁶ Namely the fifth year in primary school and the first one in secondary school (1st form in British secondary schools).

¹⁷ Namely the last year in a *collège* (4th form in British secondary schools), and the first one in a *lycée* (5th form in British secondary schools).

¹⁸ Decree n° 2005-347 of April 14th, 2005 ratifying the national reference document on risk reduction actions for drug users and completing Public Health regulations, NOR: SANP0521129D.

Budget

The funds invested by the MILDT for prevention in 2004 are shown in [Table 6](#).

The disparity of budget allocation on the line referring to actions carried out for prevention programmes in the départements can be explained by budgets being established in 2003 on the basis of 75% of the current devices (CDO, prevention, CIRDD). In 2004, according to départements, some CIRDD devices happen not to have been reduced of 25% or some CDOs have been granted more money.

From 2006 onwards project leaders will be asked to produce indicators about the setting up of their own département-level plans (decentralized government plan).

In 2003 INPES expenses for prevention amounted to a little more than € 100,000.

Table 6: Prevention actions financed by MILDT funds from 2002 to 2004 (in thousands of Euros)

Types of actions	2002	2003	2004
Actions performed within the realm of prevention programmes in the départements (managed by “drugs and drug addiction” project leaders)	6.6	7.11	18.2
Local actions under the authority or management of:			
<i>National Education (through the CESC)s</i>	1.30	0	--
<i>Ministry of Sports</i>	1.30	0	--
<i>Agriculture (agricultural education)</i>	0.13	0	--
<i>Other decentralized services (PFAD & FRAD, etc.)</i>	0.50	?	--
<i>Head of network associations</i>	1.00	0.94	1.05
Total	10.83	8.05	19.25

Source: MILDT, 2004.

3.2 Selective/indicated prevention

NO NEW INFORMATION AVAILABLE

No new element relating to that theme apart from the fact that “cannabis” consultation facilities (*See subsection on global prevention to communities*) shall be able to treat more challenging users.

4. Problem drug use

Problem drug use: general context

Prevalence and incidence estimates: An estimate was made of the national prevalence of problematic use of heroin and cocaine in the population aged 15-54, using the demographic estimation method and data from the "November" survey of 1999 (Costes, 2003). The result obtained was 4.6 per thousand [Standard table no. 7].

Local estimates were made in 1999 of the prevalence of use of opiates and cocaine (heroin, Skenan®, Subutex®, methadone and cocaine) concurrently in five French cities, using the capture-recapture method: the estimates varied from 15.3 per thousand people aged 15 to 59 in Nice to 6.5 per thousand people aged 15 to 59 in Toulouse (Chevallier, 2001), [Standard table no. 8].

The number of problem opiate or cocaine users was estimated to be between 150,000 and 180,000 in 1999.

There are currently several French-language tools allowing evaluation of abuse or harmful use of cannabis among adolescents or young adults. These are two tests translated from English and one specific test for cannabis devised by OFDT: CAST (Cannabis Abuse Screening Test).

Until there is a European definition, the definition of problematic use of cannabis selected for use in France is as follows: "use likely to cause significant health and social damage to oneself or others".

France has just been granted a system for recording requests for treatment in accordance with the European protocol (TDI – [TDI; Standard tables nos. 3 and 4]). Until the first results of the common data collection on addictions and treatments (RECAP) are published in 2005-2006, the information on the profile of people undergoing treatment comes from:

- the "November" survey carried out by the Directorate for research, studies and evaluation of statistics (DREES) at treatment centres in a given month
- annual activity reports from the specialised centres for drug addicts (CSST) which contain a set of questions which can be used to give a brief picture of the patients treated during the year. The latest figures available date from 2003.
- the OPPIDUM survey (Observation des produits détournés de leur utilisation médicamenteuse (Monitoring of illegal psychotropic substances or those that are used for purposes other than medicinal)), on use during the past week by users treated in a range of facilities, mainly CSST's, during a given month
- the specific survey among users attending low threshold facilities (drop-in centres and syringe exchange programmes) called the "front-line" survey, carried out in the twelve sites which form the French monitoring facility for recent trends (TREND).

Profile of people undergoing treatment and attending the low threshold facilities: the people seen in the CSST's or the low threshold facilities are mainly men (around 80% of those attending). The average age of those treated in the CSST's has been rising since the end of the 1980's (this applies to people aged more than 40 but also to minors). The age of the patient varies depending on the product which is the reason for treatment: people whose treatment is linked to opiate use have an average age of 31, while those whose treatment is the result of problematic use of cannabis are around 25 years old.

Each year, around 50% of people treated in CSST's are new patients. Of these, a third attend of their own volition (around 35%), 18% following a court order and 20% are referred by health institutions. Between 1998 and 2002, an increase in the proportion referred by the courts was noted among new patients (13% in 1998 and 20% in 2002). The main products giving rise to a need for treatment were opiates. Since 1998 there has been an increase in the demand for treatment for dependence on cannabis (Costes *et al.*, 2005; Delile, 2003; Palle and Bernard, 2004; Palle *et al.*, 2003).

In 2003, among users of the low threshold facilities, the illicit substances used most within the past month, apart from cannabis, were, in decreasing order, cocaine hydrochloride, ecstasy,

heroin and amphetamines. HDB and benzodiazepines are used by an important share of individuals (Bello *et al.*, 2003; Bello *et al.*, 2004).

From the observation of different social groups at risk in 2003 it was noted that cocaine use was spreading and involves social profiles which are increasingly diversified. Likewise ecstasy uses are more and more observed among urban streets users. Hallucinogens also appear to be more and more taken by the youngest users (Bello *et al.*, 2004).

HDB misuses have been identified, probably more common because such substance is available on urban alternative markets. Injection and sniffing of this product were highlighted among users of low threshold facilities, together with non-substitution use (primary use and primary dependence) (Bello *et al.*, 2003; Bello *et al.*, 2004; Cadet-Taïrou *et al.*, 2004a; Escots and Fahet, 2003).

Since 2001 the recent injection practice has been decreasing while sniffing seems to expand (Bello *et al.*, 2003; Bello *et al.*, 2004 ; CEIP de Marseille, 2004; Palle *et al.*, 2003). But field data collected in 2003 supply contradictory pieces of information: some TREND locations report an involution of injection whereas others notice some appeal to that practice among the youngest populations (Bello *et al.*, 2004).

Among those who had injected during the past month, it was found in 2003 that almost 25% of injectors had shared their equipment. Three quarters of sniffers had shared their product and 45% their straws (Bello *et al.*, 2004).

New developments in relation to use are reported in [Standard table no. 17].

4.1 Prevalence and incidence estimates

NO NEW INFORMATION AVAILABLE

Cannabis problematic use

See [Cannabis contexts of use](#)

4.2 Profile of clients in treatment (characteristics, method of use)

In 2003 the active line of outpatients treated in CSSTs may be extrapolated to nearly 75,000 individuals, half of them being new ones, yet such figures include double counts whose proportion proves difficult to be assessed; the average active line per facility amounts to 363 individuals, of which half of them are newcomers (Palle *et al.*, 2005).

Seventy-eight percent of patients are males. The age distribution is detailed in [Table 7](#). A slight majority of patients (52%) are 30 years-old or more and 16% are 40 or over; 30% are under 25, and 6% are teenagers. Newcomers are notably younger: there are a bit more than 40% of them under 25 years-old. Such data seem to echo the diversity of the attendance, which is polarized between patients treated with opiate substitutes, on one hand, and individuals consulting on account of troubles induced by the use of cannabis, on the other hand.

Table 7: Distribution of all outpatients according to age (in percentage), 1998-2003

	1998	1999	2000	2001	2002	2003
Under 18	3.3	3.8	4.5	5.1	5.2	6.1
18 to 24	23.4	19.8	19.8	21.7	22.6	23.7
25 to 29	27.9	25.7	24.2	22.0	19.7	18.5
30 to 39	38.7	41.6	40.3	38.2	38.3	35.7
40 and over	6.6	9.0	11.2	13.0	14.2	16.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: exploitation of the CSSTs standard annual reports for outpatients covering the 1998 /2003 period, DGS/OFDT.

Among other available features relating to patients, 72% of them are living in steady accommodation, 20% in unstable housing, and 7% are homeless. As far as newcomers are concerned, such data are more or less similar.

A little more than one third (35%) of patients get money from their earned incomes, 20% of them from RMI (Minimum Income), 12% from ASSEDIC (jobseeker's allowance), and 7% from AAH (Adult disability allowance). Fifteen percent are financially dependent on someone, and 11% rank under the "others" category that includes individuals having no income. Nearly 96% of patients benefit from social security cover. The new patients' characteristics are similar.

Following the trends observed from years 2000 onwards, the share of opiates within substances inducing treatment has been decreasing in favour of cannabis essentially, and stimulants (cocaine, crack, ecstasy) to a slight extent (Table 8). For the first time in 2003 cannabis ranks first for inducing new treatment requests, but we will have to wait until next year in order to know if such trend is confirmed. Among the whole set of answers to the question about substances, there are nevertheless 8% of "no substance used" answers.

The use of intravenous injection among new patients has still been decreasing this year. Such a drop must be compared with the increase of treatment requests for problematic cannabis use.

The rise of the share including the youngest individuals among newcomers may be compared with many other indicators:

- Increase of cannabis share as a substance inducing treatment;
- Increase of the ratio of patients having steady accommodation within a family context;
- Increase of the ratio of patients financially dependent on someone;
- Increase of the ratio of patients coming to the facility further to a treatment order.

Table 8: Distribution of new patients according to substances inducing treatment (in percentage), 1998-2003

	1998 11687 patients	1999 11361 patients	2000 17097 patients	2001 16619 patients	2002 24208 patients	2003 24422 patients
Heroin	41.0	35.7	34.8	35.7	34.1	29.2
Cocaine	5.7	5.9	5.7	6.6	6.5	5.8
<i>among which crack alone</i>	1.8	1.5	1.3	2.4	2.4	1.3
LSD & other hallucinogens	1.0	0.9	1.5	1.1	0.6	0.8
Cannabis & by-products	24.2	26.7	27.5	28.9	31.3	39.9
Amphetamines	2.3	1.4	2.4	2.5	2.5	2.3
<i>among which ecstasy alone</i>	0.9	0.8	1.5	1.4	1.5	1.6
Solvents	0.1	0.1	0.3	0.2	0.1	0.1
Codeine by-products	3.1	2.2	2.0	1.5	1.2	0.9
Buprenorphine-methadone	9.2	12.5	11.0	7.8	7.9	7.5
Non opiate psychotropic medicines	4.8	4.6	4.1	3.2	3.3	2.7
Alcohol	5.9	7.7	7.9	8.6	10.0	8.7
Others	2.7	2.3	2.8	3.9	2.6	2.1
All substances	100.0	100.0	100.0	100.0	100.0	100.0

Source: exploitation of CSSTs standard annual reports for outpatients covering the 1998 /2003 period, DGS/OFDT.

4.3 Principal characteristics and method of use obtained from sources other than treatment

Crack users

The first convention pertaining to crack has been held on June 8th and 9th, 2005, on which occasion exchange of views have taken place between politicians, residents, policemen, and drug addiction experts and contributors. The amount of users has been estimated between 6,000 and 10,000, of which half live in Parisian region. As far as France is concerned, there is no dramatic increase in the number of crack users, yet their poverty stands for the unequivocal cause of their increasing attendance in reception and treatment facilities. During that convention debates have essentially focused on the reception of individuals, their more or less challenging presence in some specifically outlined neighbourhoods within Paris and Seine-Saint-Denis département (“Not In My Backyard” Syndrome), as well as on trafficking repression (Convention on crack wandering and polydrug addiction, June 14th, 2005).

TREND Investigations

The last survey available on users attending “low threshold” facilities dates back from year 2003, and its results have been published in last National Report (Bello *et al.*, 2004, enquête « première ligne 2003 », TREND/OFDT). In 2004, TREND has carried out many investigations in specific themes or populations, which are developed below (Bello *et al.*, 2005c).

Injection

Some indicators may suggest that the injection practice has been decreasing for some years in France.

All pieces of information produced by the various observation devices within care structures (CSSTs, health and social facilities, “low threshold” structures) meet the same findings: a decrease of injection prevalence and incidence among drug users. Among the individuals met in CSST, the share of lifetime injection has dropped from 72% in 1993 down to 51% in 2003, and for monthly injection from 17% in 1997 down to 12% in 2003 (Bellamy, 2005). In health and social facilities, weekly injection has dropped from 29% in 1996 to 9% in 2004 (CEIP de Marseille, 2005). Finally, among users surveyed in low threshold facilities, whereas in 2001 54% of them would declare having resorted to injection during the previous month, they only amount to 37% in 2003 (Graph 1) (Bello *et al.*, 2004, “2003 low threshold survey”, TREND/OFDT).

Three major factors might account for such a decrease:

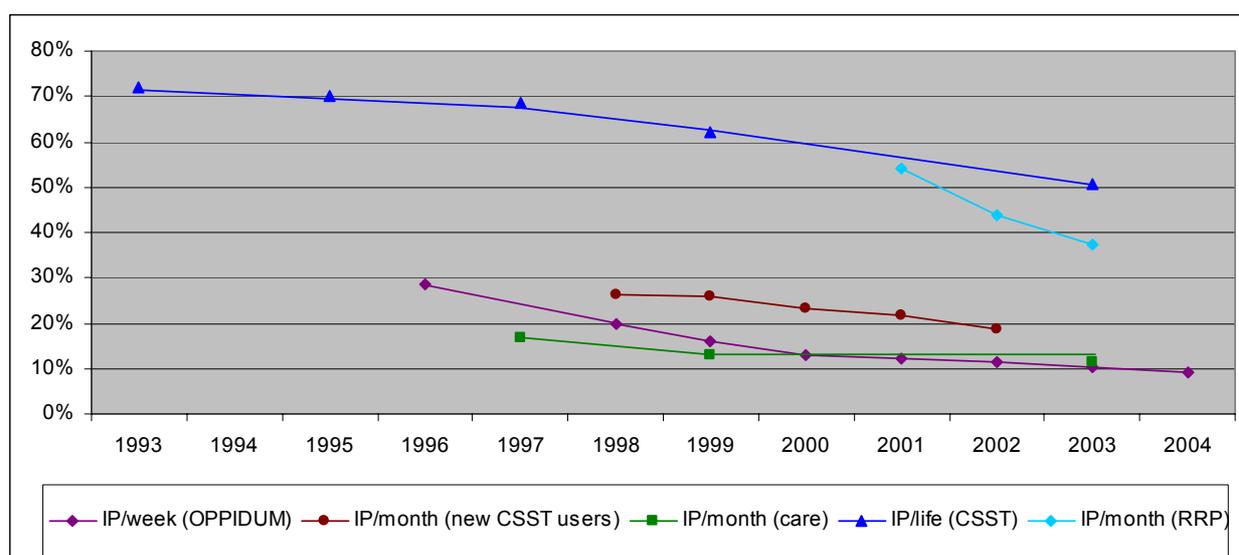
- Younger generations using hallucinogenic substances and stimulants rather than opiates;
- A widespread distribution of substitution substances and therefore an increasing number of individuals being granted treatment;
- A negative image of the injection practice on account of infection risks (HIV, HVC) or other painful morbid symptoms.

In 2003 within the urban area, injectors attending “low threshold” facilities are mostly males (79%), of over 25 years-old (81%), and whose education ranks under the Baccalauréat level (79%) (Bello *et al.*, 2004, “2003 low threshold survey”, TREND/OFDT). Thanks to numerous data on social status and modes of use collected by the survey, some factors associated with the injection practice have been detected; the injection practice during last month prior to the survey is increasing in accordance with:

- A high precariousness score¹⁹: individuals whose precariousness score ranks over 7 are twice as likely to inject themselves with a substance (OR=2.2) as those whose score ranks between 3 and 5;
- A significant number of substances used during the month: individuals having used more than 5 different substances during the month run three times as more risks (OR=3.1) to have practiced injection as those having used only one substance;
- If one opiate has been used during the month: opiate users run 16.4 times more risks to have injected themselves with the substance during the month as other users. Among opiate users the risk is higher for morphine sulphate (OR=11.3), HDB (OR=2.7), and heroin (OR=2.7).

These elements have been confirmed in 2004 by the device qualitative observations.

Graph 1: Frequency of the injection practice (IP) among drug users met during treatment, 1993-2004



Sources: TREND/OFD, 2005.

In 2003 HDB has been injected by 51 % of injectors, cocaine by 32% of them, morphine sulphate by 17%, and ketamine by 13%. In 2004, according to the urban area observers, cocaine injection would be increasing in some locations; heroine, HDB, and cocaine remaining the most frequently injected substances.

In the recreational area the injection proves less frequent than within the urban area. According to the “electronic music” survey, 4.6% of respondents declare having injected themselves with a substance during their lifetimes, and 1.1% of them during the year prior to the survey (Reynaud-Maurupt *et al.*, 2005). Such ratios obviously rank higher than those found out in adult general population, although there is no figure available for the latter.

In that area the injection practice therefore remains sporadic and restricted to a specific population: socially marginalized individuals who evolve on the dividing line between recreational and urban areas.

Elements referring to equipment sharing and infectious illnesses have been dealt with in last National Report (OFDT, 2004a).

¹⁹ Score added up for housing conditions, social security cover, and resources. It can rises from 3 to 10, and the higher it is, the more precarious condition the individual is experiencing.

Cannabis frequent uses

Supported by the TREND system, a survey among cannabis frequent users has been carried out in 2004 (Bello *et al.*, 2005b; Bello *et al.*, 2005c). The standards retained were: an age between 15 and 29 years-old, and a cannabis use of 20 joints at least during last 30 days or for 10 days at least during last 30 days. The survey has taken place in town, in the street or during a recreational moment, in the CSSTs (in which case only individuals requesting help for a cannabis use were likely to be surveyed); risk reduction facilities were not included in the chosen locations.

More than 1,500 questionnaires have been exploited. The respondents are mostly males. The 20-24 years-old age-bracket ranks first (41%), the education level is high (60% of respondents have a Baccalauréat degree or more), and 14% of the individuals surveyed are unemployed (the majority have a paid job or are students).

When using Duke's health score²⁰, the health conditions of cannabis frequent users may be compared with those of the general population (Table 9). It may be noticed that 20-25 years-old frequent male users register lower scores than general population males within the same age-bracket, while such disparities cannot be observed among females. The same trend can be also noticed when it comes to the depression score. As far as the anxiety score is concerned, disparities between frequent users and general population stand out for both genders.

Table 9: Health, anxiety, and depression scores issuing from the Duke health profile among cannabis frequent users and in general population

	Cannabis frequent users ⁽¹⁾				General population ⁽²⁾	
	Together		20-25		20-25	
	Males N=1 145	Females N=445	Males N=535	Females N=227	Males N=583	Females N=731
Physical health	75.9	69.0	76.3	71.9	81.3	71.8
Mental health	67.1	64.5	67.5	67.0	76.3	69.1
Social health	65.7	66.0	65.8	68.2	72.7	68.0
Health perceived	74.9	72.4	74.3	75.6	83.5	73.0
General health	69.5	66.5	69.9	69.0	76.8	69.7
Anxiety score	44.2	46.2	43.8	44.2	29.7	37.1
Depression score	33.7	37.2	33.3	34.4	25.2	33.8

Note: As far as health scores are concerned, results are given on a scale ranking from 0 to 100 (optimum=100). When it comes to anxiety and depression scores, the scale also ranks from 0 to 100 but the optimum equals 0 (reverse scale from health scores).

Source: (1) "Survey on frequent cannabis users", 2004 TREND/OFD; (2) Baromètre santé 2000, (Ménard and Gautier, 2001).

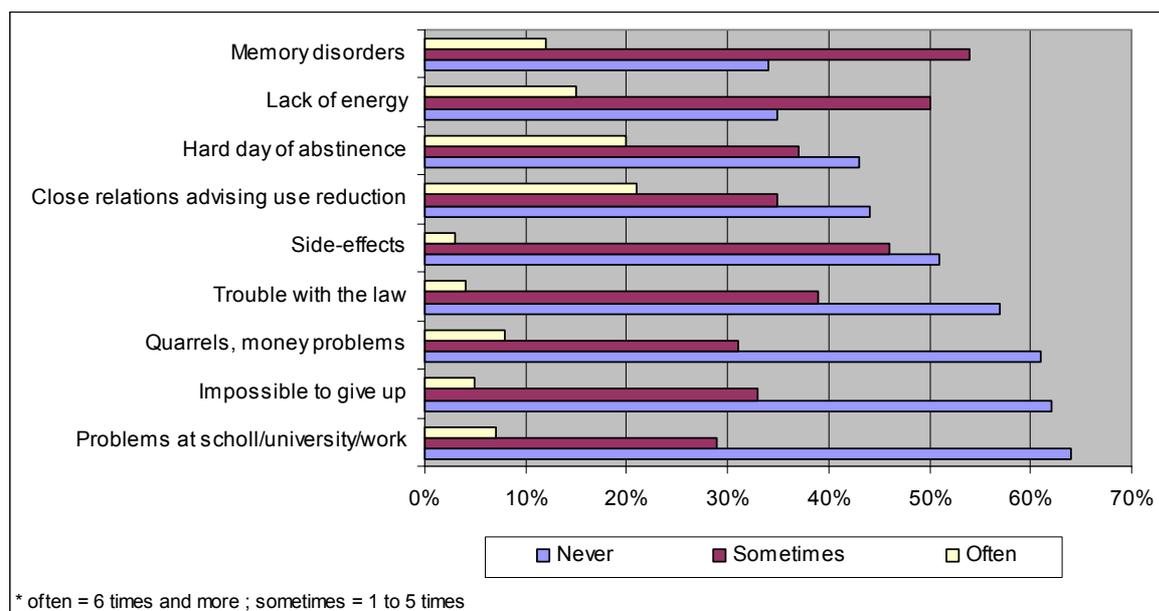
The average age for the cannabis beginners stands at 15 years and 4 months old. Nearly 8 individuals out of 10 smoke cannabis between 5 and 7 days a week, the evening being the ideal moment for using it. As expected, the weekend stands out because of the number of joints increasing when compared with those used during weekdays, yet such an intensity remains in proportion with the amount of weekdays of use. The use contexts (with friends, alone) vary, as well as motives ("to relax", "to share", and "to have a wild time"). The use locations are essential the private area (home) and the recreational one (parties, discotheques).

²⁰ Questionnaire including 17 items distributed around 5 separate scopes: physical health, social health, health perceived, disability, and 5 other scopes issuing from a combination of items: self-esteem, anxiety, depression, pain. The result is shown on a scale going from 0 to 100 (optimum=100). For anxiety and depression scores, the scale also ranks from 0 to 100, yet the optimum equals 0.

Among the population surveyed the troubles relating to cannabis use are frequent yet most of the time minor ones (Graph 2). Some factors are associated with more problematic uses: social unsteadiness, early beginning of cannabis use, modes of uses other than joints (pipe, ingestion).

About 9 individuals out of 10 register a low score of problematic use²¹ (0-4: 45 %) or a medium one (5-9: 43 %). For a 10 to 14 score, there are 11 % of individuals, while the 15 to 18 level concerns 1% of them.

Graph 2: Troubles relating to cannabis use among the 1,567 frequent users during past year, 2004



Source: "Survey on cannabis frequent users", TREND/OFDI.

Despite their increase during last years, the help requests for cannabis use among health care professionals remain low. About 20% of the individuals surveyed have resorted to a professional during the year.

Apart from their cannabis uses, the frequent users are deeply experimenting other psychoactive substances: 56% of them have used a stimulant during their lifetimes, 47% a hallucinogen, 23% an opiate. Ecstasy stands for the illicit substance mostly experimented and used beyond cannabis, followed by hallucinogenic mushrooms (Table 10).

A supplementary qualitative survey is currently under way and performed among 70 cannabis frequent users. Thorough interviews are being carried out for a better understanding of cannabis frequent users' motivations, the significances they would give to their uses, the individual and collective reasoning pertaining to uses, the consequences of uses in everyday life, and which processes would intensify or reduce them.

²¹ Problematic use items were included in the questionnaire: memory disorders, lack of energy, hard day of abstinence, close relations advising use reduction, perception of side-effects, troubles with the law, quarrels, impossibility to give up, problems at school/university/work. Answers to items have been graded as follows: (never (0), sometimes (1), often (2)). A score of problematic use likely to vary between 0 ("never" for the nine criteria) and 18 ("often" for the nine criteria) has been obtained in adding up the answers given.

Table 10: Levels of use for psychoactive substances among cannabis frequent users (in percentage) 2004

	Lifetime	Year	Month	Week
Ecstasy	45.3	16.2	15.5	6.8
Hallucinogenic mushrooms	40.8	22.1	4.6	0.8
Cocaine	40.1	12.4	12.9	4.5
Amphetamines	27.6	11.8	7.9	3.6
LSD	25.5	15.2	4.4	1.5
Heroin	20.4	11.0	4.5	2.5
Benzodiazepines	18.0	6.1	7.2	4.2
Other hallucinogenic plants	13.7	7.2	1.9	0.9
Crack	12.4	4.4	3.2	1.5
HDB (apart from substitution treatment)	10.9	5.7	2.6	1.8

Note: 1,633 cannabis frequent users have been surveyed.

Source: "Survey on cannabis frequent users", TREND/OFDT.

Users of hallucinogenic plants

Among the themes explored in 2004 by the TREND system there are the uses of natural hallucinogenic substances: hallucinogenic mushrooms, *Salvia divinorum*, *datura Stramonium*, ayahuasca, woodrose, peyotl...

The craze for such substances has been confirmed for some years within the recreational area, and is still supported by a noticeable increase of the experimentation prevalences in general population and more particularly among youngsters (for mushrooms essentially).

It has been noticed that the most often experimented hallucinogenic mushrooms are French psilocybs, followed by Mexican ones; mushrooms generally stand for the access gate to the use of natural hallucinogens. As they are widely available, perceived as not very hazardous or quite safe, their status appears as not reprehensible or even friendly. Among the experimentations of hallucinogenic plants, the *datura Stramonium* and the *Salvia divinorum* are the most common. But it seems that the experimentation of *datura* seldom recurs because the right dosage is hard to find in order to avoid side-effects. The uses of other plants, such as ayahuasca, woodrose, peyotl, are insignificant.

The user's standard profile may be described as follows:

- For mushrooms: teenagers attending school in search of experimentations, young "teufeurs"²², "converted clubbers"²³, young dropouts from the urban area;
- For *Salvia divinorum*: youngsters living in the street (Bordeaux), 20-25 years-old students or salaried workers (Toulouse), individuals attracted to psychedelia and shamanic cultures (Paris).
- For *datura Stramonium*: young dropouts and polydrug users, individuals within the techno recreational scene yet using the substance outside.

When it comes to individuals using other substances, a standard profile proves difficult to be brought out; on the whole, it concerns experimenters attracted to mysticism and/or shamanism.

²² Individual attending techno parties; term borrowed from *verlan* (French reversed language).

²³ Individual who was once attending free-parties but is now going to clubs and discos.

Table 11: Experimentation and use of hallucinogenic mushrooms among users attending low threshold facilities and within the electronic music recreational area (in %)

	2003 Low threshold (n=1 082)		2004/2005 Electronic music recreational area (n=1 496)	
	10 times during lifetime	In last 30 days	Experimentation	In last 30 days
Hallucinogenic mushrooms	40 %	14 %	54.9 %	12.4 %

Sources: "2003 Low threshold" Survey, TREND/OFDT; "Survey on the electronic music recreational area", GRVS/TREND/OFDT.

Mushrooms are mostly infused or eaten raw. *Datura Stramonium* is infused for reducing its toxic effects, while *Salvia divinorum* is used with a pipe or a bang.

Natural hallucinogens are mainly used collectively, most of the time among friends. The main motivations for using such substances fall within three criteria: cost/availability, easiness/difficulty to cope with side-effects, and perception of the substance.

The supplying sources differ from those of other illicit drugs. In most cases, such substances are given, lent or bartered, but seldom sold. The only reason for such practices depends on the supplying system which is essentially based on picking and collecting. Home growing, purchases on the Net are other supplying methods.

Using hallucinogenic substances is mainly for users a way of altering the existing circumstances (recreational incentive or re-enchanting the world); in such cases they are used communally. For a minority of individuals, the use helps to be carried away (dreamlike travel; medium to a hidden world, not regarded as sacred; medium to a mystical world) and rather occurs on one's own.

Troubles issuing from the use of hallucinogenic plants are mostly psychiatric and treated by emergency wards. Apart from *datura Stramonium*, few troubles are mentioned as being directly relating to the intakes of such substances, yet psychical consequences may occur: "bad trips", fits of anxiety, mood disorders, etc. Users of natural hallucinogenic substances actually acknowledge significant physical and psychical side-effects due to *datura Stramonium*: digestive disorders, exhaustion, ocular disorders, loss of spatiotemporal bearings, memory loss, emotional collapse, mental disorders...

Among all drugs, natural hallucinogenic substances are those benefiting from the most positive perceptions (save for cannabis perhaps):

- On account of the "organic" or "healthy" natural connotation;
- Because of strong connections with mysticism;
- Because some plants are sold over-the-counter in French border countries, and that helps putting their illicit characteristics into perspective;
- Because the risk of becoming addicted to them is hardly ever considered;
- Because the risks following an intake are regarded as controllable and manageable without any outside help.

Nomadic users or users experiencing urban wandering

For three years some locations belonging to the TREND system have born witness to the increasing visibility of a population which characterizes itself as follows: young (15-30 years-old), nomadic or wandering, attending the urban recreational area, living in highly precarious conditions, using many psychotropic substances, and hardly ever seen in low threshold and

care structures. In 2004 the TREND system has therefore attempted to develop a better knowledge of such a group by making a distinction between “nomads”²⁴ and “wanderers”²⁵.

In Metropolitan France the population of young dropouts is then divided up among “nomads” and “wanderers”, whereas in overseas locations (Martinique, French Guiana) it quite essentially includes “wanderers”.

“Wanderers” characterized themselves by being mostly males, a high proportion of individuals under 25 and minors, highly precarious living conditions, and a strong disconnection from family, school, and society. As for “nomads”, most of them are older than “wanderers”, are more often granted welfare payments, and therefore live in less precarious conditions than “wanderers”.

The dropout status of “nomads” is claimed as a way of life. But the distinction between both categories is quite trivial: it is generally due to the social paths followed (backgrounds), and each individual’s own perception is often unclear (some “wanderers” describe themselves as “nomads”).

There is no significant difference among the substances used between both groups, yet uses seem generally more controlled among “nomadic”²⁶ populations. In some locations both groups can influence each other; for example, an important development of the uses of natural hallucinogens and ketamine has been observed among “wanderers” in touch with the recreational scene (and therefore with “nomads”).

There is a high level of heroin uses in both groups, as well as for polydrug use practices and the alcohol/cannabis combination becoming commonplace. In the “wandering” population polydrug use is anarchically experienced: “*we find and combine what we can*”. In this group HDB is extremely present, as well as benzodiazepines in polydrug uses. The prevalence of injection is low among the youngest (under 25) yet increasing along with age and the level of disconnection (in both populations), although it is badly perceived within each group.

Among health and social problems experienced by “wanderers” or “nomads”, drawing the line between the consequences of uses themselves and what is due to a specific lifestyle proves difficult. The most frequent problems are psychiatric or psychical disorders, health troubles due to poverty or the use of substances and more notably of opiates, as well as a high exposure for females (sexual abuses, unwanted pregnancies...).

The emergence of “nomads” and “wanderers” in “low threshold” structures present professionals with a number of difficulties:

- Facilities unfit for young individuals frequently turning up with dogs;
- Medical treatment for an increasingly mixed population (“nomads”, “wanderers”, “standard” users);
- Impossibility to start a long-term work with both populations.

Recreational area relating to electronic music

See article [Drug Use in French Recreational Areas: Situation in 2004 and Recent Evolutions](#) included in this document. An thorough report on the investigation carried out will be available by the end of 2005 (Reynaud-Maurupt *et al.*, 2005).

²⁴ “Nomads” characterized themselves by their accepted even chosen dropout lifestyles. Individuals from such group mostly claim to belong to a counterculture coming within specific musical. It is a mobile population, moving in accordance to either recreational or other events.

²⁵ “Wanderers” characterized themselves by unwanted dropout lifestyles mostly regardless of either cultural or other aspects. They are generally more “atomized” than “nomads”, and apt to settle somewhere with a restricted wandering.

²⁶ This survey supplies no prevalence figures for the various uses; only the spectrum of substances used is available.

5. Drug related Treatment

Drug related Treatment: general context

In regard to treatment, the aim of the authorities' strategy is to offer a varied range of treatments and services in order to offer each person the most appropriate response for his or her way of life and to attempt to improve the quality of treatment. Three systems are used in the treatment of users of illicit drugs: the system for specialised treatment of addiction (medical-welfare establishments), the general practice treatment system (hospitals and general practitioners) and the risk-reduction system.

1. The specialised system

Since the beginning of the 1970's, the responsibility for addictions to illicit drugs has rested with the specialist facilities. These facilities were developed after the adoption of the 1970 law, which included provisions guaranteeing anonymous treatment, free of charge, to all users of illicit drugs who wanted to be treated. Almost all French departments today have a specialised centre for drug addicts (CSST).

These facilities were originally financed by the State and since 1st January 2003 have been funded by national insurance as medical and welfare establishments. Their mission is to provide, jointly, medical, social and educational treatment which includes assistance with social integration or re-integration.

There are three types of CSST:

- outpatient treatment centres (201 in 2003)
- inpatient treatment centres providing group accommodation (42 in 2003)
- treatment centres in prisons (16 in 2003)

The outpatient CSST's meet the needs of patients who want withdrawal while remaining outpatients. They can also organise withdrawal in a hospital environment and assist patients who wish to use this method. In regard to substitution, since 1993/1994 and until recently (2002), the CSST's were the only facilities in which a patient could begin methadone treatment. Prescription of this could then be passed over to a general practitioner. The patients can also be prescribed HDB by a CSST. The patients may also ask the facility for support, psycho-therapeutic assistance and assistance with social reintegration.

In France the "Drug Free Treatment" is not really in use, and it seems difficult to make it match a specific type of institution or treatments. But the new Five-Year Plan for 2004-2008 recommends the development of non-substitution programmes and particularly therapeutic communities.

2. The general practice system

The development of the specialised treatment system does not meet all the treatment needs of users of illicit drugs. During the 1990's the accent was on improving care of patients with addiction problems within the general practice treatment system (hospitals and general practitioners).

2.1 The hospitals

Within the hospitals (health institutions), treatment of addictions is based on liaison and addiction treatment teams, the town-hospital networks and the provision of hospital beds for withdrawal cases and the performance of medical, psychological and welfare assessments.

The liaison and addiction treatment teams were created by the circular of 3rd April 1996 and are composed in principle of three people, one of whom is a hospital doctor. Their mission is to train and assist the hospital nursing teams, to draw up treatment protocols and to treat in-patients and emergency cases. These teams must also develop links with the treatment system to enable medical, psychological and welfare follow-up of the patients. Their actions within the institution include prevention, information and increasing awareness. In 2003 around a hundred health institutions had active liaison teams. A large part of the activity of these teams is, however, dedicated to the problem of addiction to alcohol and tobacco.

The town-hospital networks were also created by the circular of 3rd April 1996. In 1998 there were 67 networks, spread throughout the territory. They are financed jointly by sickness insurance credits and State credits.

Finally, it should be noted that since 2002, any doctor practising in a health institution has been authorised to prescribe methadone.

2.2 General practitioners

General practitioners in France today play a central role in the prescription of opiate-substitution treatments. They have been able since 1996 to prescribe HDB to opiate-dependent patients. They may also prescribe methadone after initiation of treatment by a CSST.

General practitioners are also the first to be able to treat patients who are beginning to use illicit drugs. The authorities are therefore arranging to introduce training for general practitioners on the identification of use and the most appropriate treatment methods.

From the data supplied by the *Caisse primaire d'assurance maladie* (CPAM, Department of Health office) among 13 different cities, it has been established that 35% of general practitioners had prescribed a substitution treatment during the second half of 2002. But doctors often remain quite few to prescribe methadone or HDB. The average "standard dose" for a patient on Subutex® amounts to 9.6 mg (highest recommended dose: 16 mg/day), and 98.4 mg for a patient on methadone (highest recommended dose: 100 mg/day) (Cadet-Tairou and Cholley, 2004).

3. Risk-reduction system (see box 7, "response to health problems")

The [Standard Table no.21] gives information on the different treatments used in France and their availability. The [Structured questionnaire no. 27] supplies additional information on treatment programmes available.

Treatment based on opiate-substitution is relatively recent in France (1996) and was introduced to deal with the epidemic linked to HIV.

Thanks to the development of substitution treatments, drug withdrawal programmes have become less frequent since the mid-eighties. In 2002 about 2,200 outpatients have undergone such a programme within the realm of CSST's. In 2003 there was an estimate of 63,000 to 69,000 individuals following a treatment process (Cadet-Tairou *et al.*, 2004b), that is less than half the evaluated number of opiate users in France.

Prescribing methadone substitution treatments (following an early stage begun in a specialised institution) has been allowed to urban practitioners in 1995. The amount of individuals on methadone prescribed by urban GP's has been estimated between 11,200 and 16,900 according to sales data (SIAMOIS / OFDT).

Acknowledging that access to substitution treatments in specialised centres is insufficient to meet requirements, a parallel treatment based on HDB was instigated in 1996. The methods for beginning treatment and for prescription were more flexible than those for methadone: prescription was authorised by any doctor, without special conditions of practice and the maximum prescription is for 28 days, split into dispensing every 7 days, unless expressly stated otherwise. In 2002, between 71,800 and 84,500 individuals have been prescribed Subutex®. *"Among them 52,000 at most were undergoing a six-month treatment process at least; 22,000 at least were beginning a treatment or 'in-between substitution', and 6% (5,000 individuals) were carrying out an important 'dealing' activity"* (Cadet-Tairou *et al.*, 2004b).

In parallel to the beneficial effects noted since the introduction of substitution treatments (positive impact in regard to health and social reintegration), undesirable consequences, almost exclusively reported for HDB, have also been observed. Misuse is mainly linked to the flexible framework for prescribing the product: misuse involves injection of HDB, also in patients under medical supervision, a use which does not comply with medical protocol (non-substitution use) and use in association with other products (benzodiazepines, alcohol etc.).

5.1 System

NO NEW INFORMATION AVAILABLE

5.2 "Drug free treatment"

NO NEW INFORMATION AVAILABLE

5.3 Medically assisted treatments (withdrawal, substitution)

Withdrawals operated in CSSTs

In 2003 the number of consultations or medical treatments operated per patient in the French CSSTs is on average close to 17 per year, of which a little more than 4 medical consultations (including psychiatric ones), 7 nursing treatments, 3 socioeducational private interviews, and a little more than 2 psychotherapeutic interviews (Palle *et al.*, 2005, 195 CSSTs have responded, namely a response rate of 95%).

On average 11 individuals per facility have undergone an outpatient withdrawal treatment, and nearly 9 of them have gone through withdrawal with a decreasing dosage of the substitution treatment (Table 12). It must nevertheless be considered that in the totality of CSSTs, a bit more than half declare no outpatient withdrawal treatment. Many withdrawal treatments are also performed in hospitals, but the information system has not been able to account for them satisfyingly so far.

Table 12: Average number of patients undergoing withdrawal treatment, per facility, 1998-2003

	1998	1999	2000	2001	2002	2003
Average number of outpatients undergoing withdrawal treatment operated by the CSST (per facility)	6.8	5.7	6.2	8.4	10.6	11.0
Average number of patients undergoing withdrawal through decreasing dose of substitution treatments	5.7	4.6	5.9	7.0	11.1	8.6

Reading: on average 6.8 outpatients per CSST have undergone a withdrawal treatment operated by the CSST in 1998.

Note: assessment operated while excluding facilities having performed more than 150 withdrawal treatments or not having answered questions relating to their activities.

Source: exploitation of CSSTs standard annual reports on outpatients, covering the 1998/2003 period, DGS/OFDT.

Substitution

CSST outpatients

On average about 70 patients per facility have been prescribed methadone by their CSST, nearly 55 have been prescribed HDB (in the 195 CSSTs having responded, that is 95 % of response rate). In 2003 the total amount of patients being prescribed a substitution treatment by a CSST may be estimated at nearly 27,000 (about 15,000 for methadone, and a little more than 12,000 for HDB).

The only noticeable evolution between 2002 and 2003 refers to substitution: following a regular increase of the average number of patients being prescribed methadone or HDB by CSST from 1998 onwards, such average number has remained steady in 2003 for methadone, and decreased for HDB; the year 2003 seems therefore to stand dramatically out from the previous trend (Palle *et al.*, 2005) (Table 14).

Table 13: Number of patients being prescribed a substitution treatment in a facility, 1998-2003

	1998	1999	2000	2001	2002	2003
Number of facilities accounted for ⁽¹⁾	157	135	159	147	163	187
Number of patients on methadone	5,503	6,338	7,946	8,722	11,257	13,030
Number of patients on HDB	6,493	6,541	8,006	7,633	9,330	10,236
Number of patients on treatment aiming at substitution, other cases	462	338	534	274	282	nd

Note: revised figures in comparison with 1998-2001 data.

(1) Facilities having supplied data on their activities. Besides data issuing from both CSSTs, whose active attendance includes more than 1,000 individuals or whose presence/absence in the database is likely to cause strong disparities in results from one year to the other, have not been accounted for. Lastly and still for the sake of comparison between data, figures issuing from the methadone bus have not been accounted for in 2003.

Source: exploitation of CSSTs standard annual reports for outpatients covering the 1998/2003 period, DGS/OFDT.

Table 14: Average number of patients per facility being prescribed a substitution treatment in the facility, 1998-2003

	1998	1999	2000	2001	2002	2003
Average number of patients per facility on methadone substitution treatment	35.1	46.9	50.0	59.3	69.1	69.7
Average number of patients per facility on HDB substitution treatment	41.4	48.5	50.4	51.9	57.2	54.7
Average number of patients per facility on other substitution treatment	2.9	2.5	3.4	1.9	1.7	3.9

Source: exploitation of CSSTs standard annual reports for outpatients covering the 1998/2003 period, DGS/OFDT.

Cohort studies

Cohort on methadone or high dose buprenorphine between 1996 and 2001

The goal of the survey carried out within the Centre Addictions-Sud in Marseilles was to show the evolution of the characteristics of individuals treated between 1996 and 2001, and to evaluate the patients' profiles according to the substitution treatment prescribed (patients showing a major drug dependency to opiates having turned up at the centre for a hospital consultation; the individual could subsequently be prescribed or not a substitution — methadone or HDB — treatment).

Among the 585 patients having undergone substitution treatments between 1996 and 2001, the increase of unsteady job conditions and suicide attempts have been underlined over that period. As for overdoses and psychiatric hospitalizations, they have remained mostly stable. The substances used and the practices have also changed: decrease in the proportion of heroin users and injectors, rise of LSD, cannabis, and amphetamine users, as well as a significant increase of alcohol users and patients on permanent treatment involving benzodiazepines or neuroleptics.

When treated 60% of patients were put on methadone, and 40% on HDB. Individuals included in the methadone protocol were more or less older and more often HIV or HVC infected than those treated by HDB. The share of patients having undergone previous approaches for withdrawal or substitution treatment and carrying on injection practices was higher in the group of patients on methadone. The medical and psychiatric evaluation shows that both groups were comparable as far as suicide attempts and previous history of psychiatric hospitalizations were concerned. On the other hand the proportion of patients having previous history of overdoses was higher in the methadone group.

Throughout the period covered by the study, HDB seems to have been prescribed with a primary view to the younger individuals who had not previously resorted to methadone,

whereas methadone was more frequently bestowed with a second view to patients having already approached substitution or withdrawal treatments, as well as remaining “active” drug addicts with serious viral infections. The option of substitution treatment seems then to depend on the patient’s choice and the practitioner’s experience (Lançon *et al.*, 2004).

Early breaking off during HDB treatment: identifying the risk factors

From the follow-up of 1,085 on high dose buprenorphine (HDB) substitution treatment prescribed by doctors (GPs or CSSTs), an evaluation carried out some months later has enabled detecting the risk factors of an early breaking off of treatment. In the entirety of patients involved, more than half (656) have been assessed after 12 months of treatment. Their characteristics have been compared with those of patients having quitted treatment ever since their first medical consultations (91 individuals).

Age, precariousness (measured with housing and job conditions), the lack of social support, and a limited access to care (no social security or private health insurance affiliation, no previous knowledge of a prescribing doctor) seem significantly associated with early breaking off. While the survey also detects different modes of use among individuals carrying on their treatments and those having quitted ever since the first consultation (like higher uses of cocaine, crack, amphetamines, and hallucinogens, but a lower level of intravenous injection: 31.9% vs. 41.6%), such specificities are obviously connected with a generational effect rather than with actual discriminating practices (Batel *et al.*, 2004).

6. Health correlates and consequences

Health correlates and consequences: general context

Drug-related deaths:

The information system available in France relies on several systems, each of which covers some of the causes of death related to drug use. These are deaths:

- due to overdose when the deceased is the object of a court procedure (OCRTIS – Central Office for the Repression of Drug-related Offences) [Standard Tables nos. 5 and 6]. This source of statistics covers only deaths brought to the attention of the police forces or national gendarmerie and does not include deaths by overdose of French nationals recorded abroad and deaths which occur in hospital.

Since 1995, the number of deaths due to overdose recorded by the authorities has been continuously declining (-80% between 1995 and 2003). This trend is most likely due to the combined effects of the introduction of substitution treatments, the existence of harm reduction facilities and systems and changes in the products used and users' methods of use. The majority of deaths due to overdose recorded by the authorities are linked to heroin but for two years now cocaine and medicines (including Subutex® and methadone) have occupied a more and more prominent position.

- due to drug dependency (CepiDc-INSERM) [Standard Table no. 5]. This category includes all deaths for which the death certificate mentions drug dependence. For reasons connected with the information system, it does not give a reliable record of overdoses, which are often put in the category of deaths from ill-defined causes. The number of deaths due to drug dependency decline continuously between 1995 and 2000.

- with traces in the blood of psychotropic substances: DRAMES (Décès en relation avec l'abus de médicaments et de substances (Death involving abuse of medicines and substances) – AFSSAPS (French Health Products Safety Agency)) records cases where the deceased was the object of a court order, which means that deaths not declared to OCRTIS or INSERM can then be identified. Although it is still very limited in space and is in the process of being installed, this system demonstrates the non-exhaustive nature of the two preceding systems.

- linked to AIDS in intravenous drug users (InVS). The number of AIDS related deaths among intravenous injection drug users has been decreasing since 1994. The share of such deceases among the whole AIDS related deaths has become stabilized between 22 and 27% since 1998.

For lack of a cohort survey meeting EMCDDA requirements (recruiting users in treatment facilities), the OFDT has carried out one among individuals arrested for narcotic use. The SMR (Standardized Mortality Rates) show that most of the males arrested for heroin/cocaine/crack use run a risk to die five times as high as the whole of French male population; such a risk is 9.5 as high among females. The survey shows a significant decrease of the death rate among individuals arrested for heroin/cocaine/crack between both periods of inclusion (1992/93 and 1996/97), the death rates calculated all along the 4 years following the arrest going from 10.3 down to 6.2 for 1,000 individuals per year. Such a drop matches the introduction of antiviral tritherapies, the development of risk reduction policy in France, and the distribution of opiates substitution treatments (Lopez *et al.*, 2004).

Drug-related morbidity

1. Infectious diseases represent the largest proportion of the observed somatic morbidity. The estimated prevalences among drug users rely on:

- declared prevalences of HIV, HBV and HCV: the "November" survey of patients attending CSST's (Tellier, 2001) and the survey of users of low threshold facilities Bello, 2003 #19; Bello, 2004 #20} [Standard Table no. 9].

Declared prevalences of HIV, HCV and HBV vary depending on the survey and the methods of use adopted by the users (injection, sniffing). There is a lack of screening of the youngest people and those who do not inject. Declared HIV positivity among people attending low threshold facilities who had injected at some time is around 14%, compared to around 4%

among people who had never injected. For HCV, the declared prevalence among same persons who had injected at some time is 55%.

– biological prevalences of HIV and HCV in users in Marseilles: Coquelicot survey (Emmanuelli *et al.*, 2003). This survey, which was intended to be developed into a national information, highlights the gap existing between declared prevalence and measured prevalence of hepatitis C, particularly among young people. A second one has been carried out in 2004 among 1,500 users in 5 cities.

- Estimates of the incidence of AIDS cases and HIV infection. Cases of AIDS have been notified (InVS) since the start of the 1980's and notification has been compulsory since 1986. A new, anonymous system of declaration was introduced in 2003 by the circular from the Directorate General for Health (DGS) (no. 2003/60 of 10 February 2003), which makes declaration of HIV infection compulsory. This system is combined with virological monitoring of HIV.

The number of new cases of AIDS linked to injectable drugs has been falling constantly since 1994 (1 377 en 1994 versus 166 en 2003), as has the proportion of declared cases of AIDS (36% in 1991, 19% in 1997 and 12% in 2003). The number of cases of AIDS diagnosed in injecting drug users shows a similar pattern whatever the sex, with the number of cases among men still higher than those among women (around 3 men for every woman).

2. Psychiatric co-morbidity: the few works existing in France do not allow us to draw sound conclusions on the prevalences of different psychiatric pathologies among drug users (Wieviorka, 2003).

3. Other drug-related pathologies: no systematic data has been collected about the other pathologies which might accompany, or result from, drug use (other infectious complications, cardiovascular complications, traumas etc.). The survey carried out by the TREND facility of users of low threshold facilities provides information on their perception of the state of health and the appearance of certain pathologies (Bello *et al.*, 2003 ; Bello *et al.*, 2004). Pathological manifestations occur more frequently among people in the most vulnerable situations. A third of the people surveyed declared that they felt themselves to be in a poor or very bad state of physical health. Almost 70% declared they had suffered fatigue in the past month, 44% loss of weight, 4% had overdosed, 2% had had jaundice. The frequency of declared complications linked to injection was also estimated.

4. Driving: The Law of February 3rd, 2003 has created an offence which penalizes every driver whose blood test would reveal the presence of narcotics. (S)he would then be given a 2-year prison sentence and a € 4,500 fine. Sentences may extend to 3 years in prison and a € 9,000 fine in case of a combined alcohol use. Screening the driver for narcotics is mandatory in case of fatal or corporal accident yet also after any road accident, driving offence, or even when there are many conceivable reasons to suspect a narcotic use (OFDT, 2005a).

6.1 Drug-related deaths

Deaths due to overdoses (OCRTIS)

In 2004 69 deaths due to overdoses have been detected by the police and Gendarmerie services (Office central pour la répression du trafic illicite des stupéfiants (OCRTIS), 2005). Among these three are considered accidental.

Twenty-three deaths are due to heroin (including 10 in which heroin is combined with other substances), 14 to cocaine (of which 5 in which cocaine is combined with other substances).

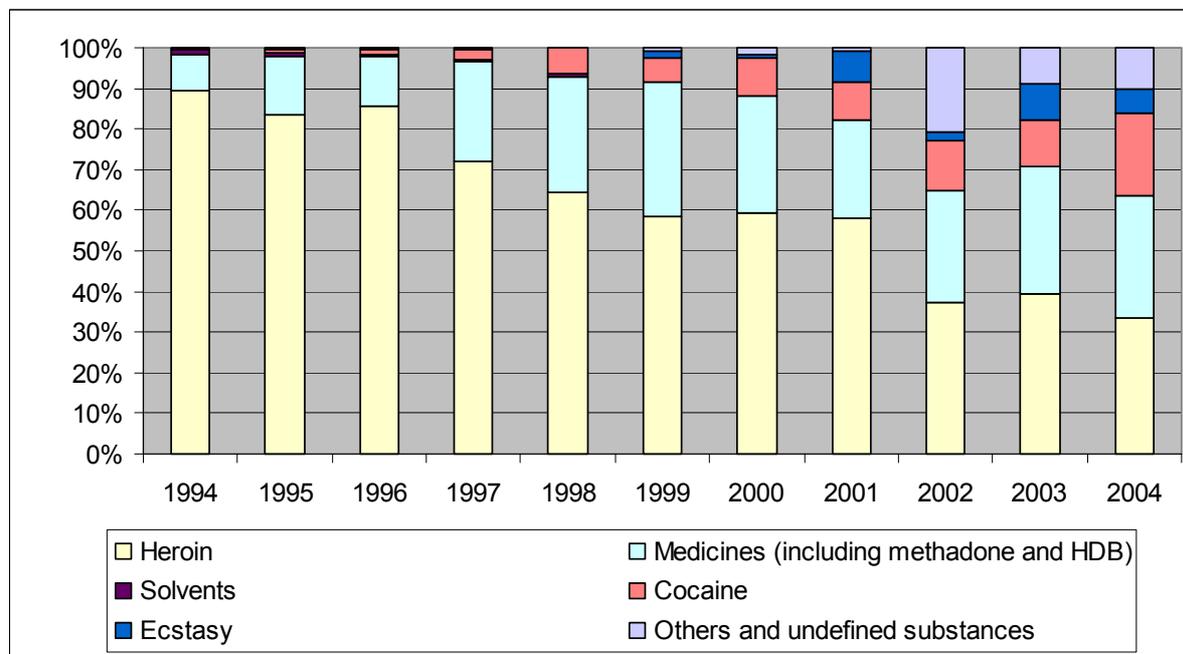
Twenty-one deaths result from medicine overdoses: 4 with Subutex® (alone and combined), 10 with methadone (alone and combined), 3 with various medicines (alone or combined), and in 4 cases the medicine could not be identified.

In 2004 4 deaths result from the use of ecstasy (vs. 8 in 2003, and 2 in 2002). An amphetamines overdose-related death has also been reported.

In one case OCRTIS mentions that cannabis has been combined with alcohol.

In one specific situation the substance(s) causing death could not been determined. Following the trends observed from late nineties onwards, the share of deaths due to heroin has been decreasing, while those caused by cocaine or psychotropic medicines are on the rise.

Graph 3: Evolution of the share taken by some psychoactive substances within all deaths due to overdoses recorded by law enforcement authorities, 1994-2004



Source: OCRTIS, OFDT operating.

Lastly, besides those 69 deceases, two deaths of French nationals in foreign countries have also been reported to repression services. The first one occurred in Vietnam on account of heroin, the second one in the Netherlands on account of an ingested cocaine ball having burst out.

Responsibility of substitution treatments in a selection of deaths

Between 1997 and 2000 more than 1,600 toxicological analysis have been carried out within the toxicological laboratory of Paris police headquarters, among which some cases have been detected with high dosage buprenorphine (HDB, 34 cases) and methadone (35) contents. In those cases, forensic pathologists have tried to determine the role of substitution medicines in the deaths: “obvious responsibility”, “possible responsibility”, “no responsibility”, and “unexplained death”. In all cases but one, HDB and methadone have been detected as being combined with other psychoactive substances. HDB happens to be directly involved in 4 cases (12%) and methadone in 3 cases (9%) (Table 15). Their possible lethal responsibility occurs in 8 cases (HDB) and 11 cases (methadone) of other deaths (Pirnay *et al.*, 2004).

The record of these death cases must be compared with the one of individuals on substitute treatments with both substances over that period. Between 70,000 and 85,000 individuals received Subutex® in 2002 (60,000 to 70,000 were undergoing treatment), whereas 10,000 to 17,000 were treated with methadone. However the survey performed by the Paris police toxicological laboratory does not enable drawing reliable conclusions on the toxic potential of each substance, as the analysis is not demonstrative on a national level, and all confusing factors have not been accounted for (treatment precedence, circumstances of its issue, drugs combined during treatment, drug addiction backgrounds, etc.)

Table 15: Responsibility of HDB and methadone as causes of death, 1997-2002

	HBD 34 cases	Methadone 35 cases
Concentration on a toxicological level	12	14
<i>Obvious responsibility</i>	4	3
<i>Possible responsibility</i>	8	11
Concentration on a non-toxicological level	22	21
<i>No responsibility</i>	18	13
<i>Unexplained death</i>	4	8

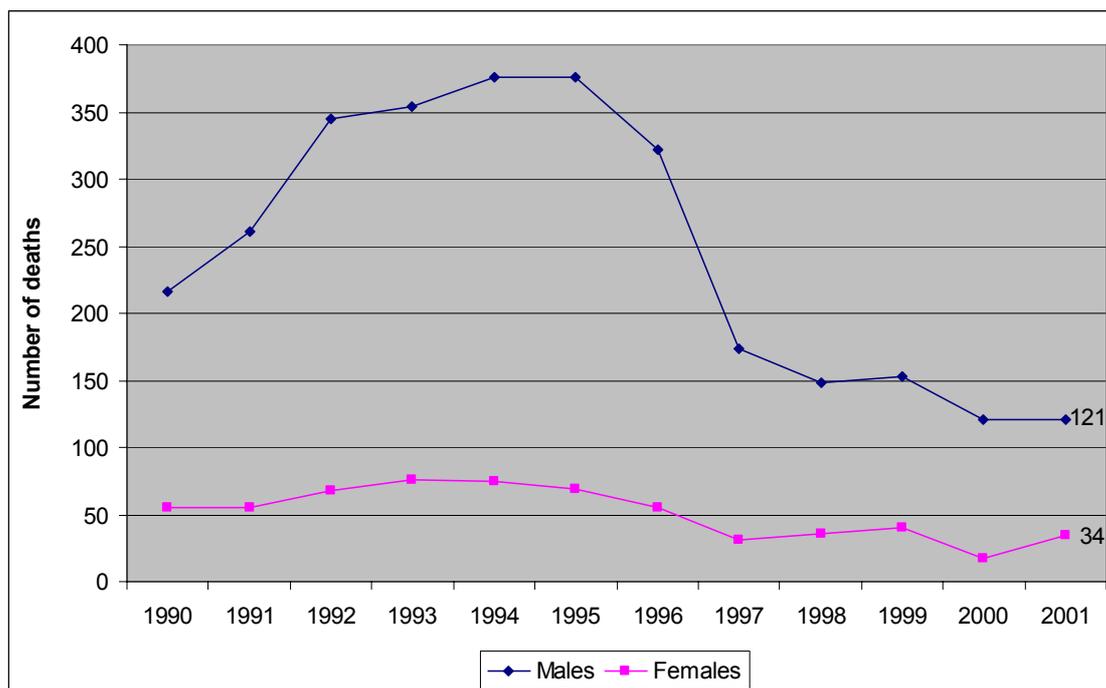
Source: (Pirnay et al., 2004).

General Mortality Register

According to the procedure set up by the EMCDDA²⁷, 155 deaths due to the use of psychoactive substances have been noted down in the General Mortality Register in 2001. As far as males are concerned, most deceases (60%) occur between 19 and 34 years-old, while among females, they happen between 35 and 64 years-old (59%).

Among most frequent death causes, including both genders, the syndrome of dependence to other substances or to multiple drugs can be found (code F19.2; standing for 80% of the whole codes selected for both genders), followed from afar by the syndrome of dependence to opiates (code F11.02; 13% among males, and 12% among females).

Graph 4: Evolution of drug-related mortality according to the EMCDDA definition, per gender, 1990-2001



Source: General Mortality Register, INSERM, Cépi-DC.

²⁷ For more details see webpage <http://www.emcdda.eu.int/?nnodeid=1419>. The indicator presented there stands for selection B from the procedure established for General Mortality Registers: it matches the selection of some death causes due to the use of psychoactive substances (Drug-related deaths – DRD) coded in ICD-10.

Changing the encoding of medical causes of deaths²⁸ had consequences for national mortality data, and more particularly for causes connected with the use of psychoactive substances; the following survey has been performed by the National Institute for Health and Medical Research (INSERM) (Pavillon *et al.*, 2004; Pavillon *et al.*, 2005). This kind of information is essential for using mortality data and analyzing the trends in death causes over time. Indeed trend evolutions may either be due to a change in categorization or in the encoding mode²⁹.

To do so, a random sample of 1999 deaths (namely 53,869 deceased) has been routinely coded in ICD9, according to the usual procedure, and coded at the same time in ICD10 by a encoding software by using the European list of death causes (ICD8-ICD9-ICD10 equivalents). The results from both systems have then been compared with each other, disparities being expressed in ratio or in absolute difference.

As for deaths connected with the abuse of psychoactive substances (notably heading 30 in the European list), results are shown in the following table:

Table 16: Deaths caused by abuse of psychoactive substances, in ICD9 and ICD10, 1999

Chapter	ICD9 (1)	ICD10 (2)	Ratio (1)/(2)
V. Mental and behavioural disorders	1,673	1,822	1.09
<i>Alcohol abuse (including alcohol psychosis)</i>	298	334	1.12
<i>Drug dependency, drug addiction</i>	36	17	0.47
XVI. Ill-defined morbid symptoms and conditions			
<i>Unknown or unspecified causes</i>	344	613	1.78
XVII. External causes of injury & poisoning	4,488	4,290	0.96
<i>Accidental poisoning</i>	78	110	1.41

Source: INSERM-CépiDC, (Pavillon *et al.*, 2005).

More particularly for deaths coded under “drug dependence” according to ICD9 (36 cases), only 17 deceases coded in ICD9 (codes 304-305) come back coded under the ICD10 matching heading (codes F11-F16 and F18-F19), namely a disparity of 19 cases (53 %) (Table 17). As for yearly data, that goes with a decrease of 190 deaths.

The 24 cases coded under heading 30 in ICD9, yet coded under other headings in ICD10, are distributed as follows: 13 cases in “mental disorders” (Chapter V, 54 %), 5 cases in “respiratory system” (Chapter VIII, 21 %), 5 cases in “external causes” (Chapter XVII, 21 %), 1 case in “circulatory system” (Chapter VII, 4 %). The 13 disparities in “mental disorders” are due to the change in revising the ICD and only refer to some specific deceases connected with the abuse of licit substances:

- Acute intoxications listed under “drug dependence, drug addiction” in ICD9 (305.0) are classified under “alcohol abuse” in ICD10 (F10.0);
- Tobacco addiction listed under “drug dependence, drug addiction” in ICD9 (305.1) comes classified under the heading “others” from Chapter V (F17.9).

Other occurring alterations are mostly due to the change of encoding mode.

²⁸ Transition from ICD9 to ICD10 encoding for deaths occurring in 2000. ICD10 stands for a major evolution in classifying since it includes 12,000 codes, whereas ICD9 only included about 6,000 ones. Using ICD10 notably enables en coding pathologies such as AIDS or more accurately characterizing other diseases as hepatitis.

²⁹ As encoding medical causes of deaths and selecting death primary cause proved more complex in ICD10, the INSERM-CépiDC had to change from a manual encoding to a routine one in order to process the French 540,000 yearly deceases.

Table 17: Detailed analysis of the distribution of “drug dependence and drug addiction” deaths in ICD9 and ICD10, 1999

		ICD10		Total	
		Heading 30 (codes F11-F16 et F18-F19)	Others		
ICD9	Heading 30 (codes 304-305)	12	24	30	36
	Others	5			
	Total	17			

Source: INSERM-CépiDC, (Pavillon et al., 2005).

Deaths due to AIDS among injecting drug users (IDUs)

Ever since 1998 the share of IDUs among the entirety of AIDS-related deaths appears fairly steady: between 20 and 27%.

Table 18: Deaths due to AIDS among injecting drug users, 1998-2004

	1998	1999	2000	2001	2002	2003*	2004*
IDUs	204	196	136	119	177	112	86
All deaths	769	708	620	583	662	476	385
IDU share	26.5%	27.7%	21.9%	20.4%	26.7%	23.5%	22.3%

* rectified data

Source: AIDS Monitoring System, InVS.

6.2 Drug-related infectious diseases

Watch system for HIV infections, new AIDS cases

Between 2003 and 2004 more than 6,000 new HIV infections have been notified in France. Contamination by injection (IDU) only stands for 3% of these new infections (the most frequent contaminating mode is the heterosexual intercourse: in 50% cases among males, and 97% for females).

Table 19: Notification of new HIV-infection diagnosed cases, 2003-2004

	2003			2004			Total		
	Females	Males	Both	Females	Males	Both	Females	Males	Both
IDUs	18	62	80	13	50	63	31	112	143
Whole new cases	1,481	1,930	3,411	1,182	1,709	2,891	2,663	3,639	6,302
IDU share (in known whole)	1.5%	3.9%	2.9%	1.4%	3.6%	2.7%	1.4%	3.8%	2.8%

Source: Notification System for HIV-infection, InVS.

The amount of new AID cases among IDUs has been steadily decreasing from the middle of 1990's onwards. The share of new AIDS cases among the IDUs, among all new recorded cases, has remained stable in 2004 when compared with both previous years.

Table 20: New AIDS cases among IDUs, 1998-2004

	1998	1999	2000	2001	2002	2003*	2004*
IDUs	355	308	246	255	201	166	150
Whole new AIDS cases	1,940	1,832	1,726	1,660	1,614	1,431	1,252
IDU share	18.3%	16.8%	14.3%	15.4%	12.4%	11.6%	12.0%

* rectified data

Source: AIDS monitoring system, InVS.

Prevalence of HIV seropositivity in France

As sero-prevalence surveys have been interrupted in France from 1997 onwards, the direct method of assessment could not have been set up beyond that year, yet estimates can be made until year 2000 thanks to the backward calculation method (Desenclos *et al.*, 2005).

Using the direct method HIV prevalence among injecting drug users (IDUs) has been assessed in 1997 at:

Table 21: HIV prevalence among IDUs in 1997 (direct method)

Age	Number	IDUs actually performing injection		
		Declared prevalence* (95 % CI)	Number** of HIV+ individuals	95% CI**
< 25	N=12, 800	4 % (1 % - 10 %)	N=500	10 – 1 000
>= 25	N=87, 200	22 % (19 % - 25 %)	N=19 200	14,600 – 23,800
Age	Number	IDUs no more performing injection		
		Observed prevalence*** (95 % CI)	Number** of HIV+ individuals	95% CI**
< 25	N=10,700	2 % (1 % - 5 %)	N=200	10 – 400
>= 25	N=48,300	16 % (14 % - 18 %)	N=7 700	4,200 – 11,300
Whole HIV+ IDUs			N=27, 600	21,700 - 33,600

CI: Confidence Interval

* Survey on syringe exchange programmes, 1998

** Number rounded up to nearest hundred

*** Survey among drug addict specialised care centres with accommodation, 1997

Source: (Desenclos *et al.*, 2005).

With the backward calculation method and considering a relative risk of pre-AIDS mortality of 10 for injecting drug users (IDUs), the added incidence of HIV infection has been calculated as follows:

Table 22: Estimate of HIV added incidence and prevalence in 2000

Population	Added incidence 1977-2000	Prevalence 2000	Relative risk of pre-AIDS deaths	Number of periods	% of medical care
IDUs	29,200 (23,300 – 38,100)	20,200 (14,300 – 29,100)	$\Psi_1=10$ and $\Psi_3=10$	2	100
Total	125,900 (90,000 - 205,600)	88,200 (52,300 - 68,000)			

Ψ_1 = relative risk of pre-AIDS mortality among HIV+ individuals when compared with HIV- ones until June 1995

Ψ_3 = ditto Ψ_1 after January 1998

Source: (Desenclos *et al.*, 2005)

HCV incidence and risk factors of transmission among IDUs

An estimate of the incidence and the risk factors of transmission of HIV and Hepatitis C Virus (HCV) among a cohort of injecting drug users (IDUs) has been carried out in Northern France (Lucidarme *et al.*, 2004).

The forecast cohort has been followed up during 12 months (medical examinations every three months). Eligible respondents were drug users whose serology was allegedly negative, having injected themselves with a substance at least once in their lifetimes, and being recruited between 1999 and 2000 in French Northern and Eastern medical care facilities. Therefore 326 have been surveyed but only 165 of them have joined the cohort (as they were HCV positive with a known serological status), and 66 have been lost sight of during the follow-up.

Throughout the follow-up year no case of HIV transmission has been recorded. The ratio of raw incidence for HCV infection amounts to 9.0/100 individuals per year (PY) (CI at 95%: [4.54 – 13.4]) in the whole cohort, and to 11/100 PY (CI at 95%: [4.7 – 17.1]) for users having injected at least once during the 6 months prior to their joining the cohort.

The relative risk of sero-conversion combined with sharing whatever useful drug equipment amounts to 3.6 (CI at 95%: [0.43 – 29.2]). The risk of HCV infection is 18 times higher (CI at 95%: [2.2 – 148.7]) when sharing cotton wool, 3.6 times higher (CI at 95%: [0.4 – 29.2]) when sharing a small dish, and 4.7 times higher (CI at 95%: [0.5 – 40.3]) when sharing water. In case of sharing syringes, the relative risk of sero-conversion ranks between 8.4 and 8.6.

The authors conclude that in the French regions surveyed, the risk of Hepatitis C transmission remains quite high among IDUs. In order to cut it down, the access to low-cost sterile equipment proves necessary.

HIV, HCV and HBV prevalence among problematic users

The results from the 2004 issue of the Coquelicot Survey carried out in 5 French cities will not be published until the end of 2005. In the beginning of 2006, the TREND/OFDI Survey on “Low threshold users” should integrate saliva samples into the collection of declarative data for measuring the prevalence of HIV, HCV and HBV infections in 4 cities not covered by the Coquelicot Survey.

A prevalence survey on blood markers for Hepatitis B and C has been performed in 2003-2004 among a national sample of individuals paying social security contributions (about 85% of the population). Selected by drawing lots those individuals were granted a general medical examination in their own local Social Security Centre. The acceptance ratio amounts to 9% leading to about 15,000 volunteers. The self-selection of entrants may stand for a bias.

Among individuals acknowledging a present or past drug use by injection, the prevalence ratio of anti-HCV antibodies is of 55.5% vs. 0.63% for the rest of the sample. Ninety-four percent of seropositive injection drug users (IDUs) know their serological status. The comparison with the same study on Hepatitis C operated ten years before shows that Hepatitis C prevalence has remained level during 10 years, yet the knowledge of its serology has more than doubled within general population, increasing even more among IDUs. The prevalence ratio for HBc antibody — which refers to an infection transmitted by the Hepatitis B virus, cured or not — amounts to 55.9% among IDUs vs. 8.0% among individuals not using drugs (INVS/CNAMTS/CETAF, 2005).

Watch system for acute Hepatitis B

The mandatory notification of acute Hepatitis B infections has been initiated in France in 2003 following its suspension in 1985. The first results of notified cases between March 1st 2003 and April 1st 2004 are now available.

One hundred and fifty-eight cases of acute Hepatitis C have been recorded throughout that period, among which 145 respondents have filled in the risk factors data. The more

widespread risk is the sexual one (40.6% of cases), drug use only registering 6.2% of new cases (5.5% by intravenous injection, and 2.8% by pernasal duct).

When comparing such figures with those collected by the “Sentinelles Network” between 1991 and 1994, a decrease in drug use transmission can be noticed (6.2% of the cases in 2003 vs. 19% in “Sentinelles”) and might be explained by vaccination recommendations for drug users being better followed (Antona *et al.*, 2005). Indeed according to the Coquelicot Survey carried out in 2001-2002, 42% of users would have received one vaccine dose at least (Emmanuelli *et al.*, 2003).

6.3 Psychiatric co-morbidities

NO NEW INFORMATION AVAILABLE

6.4 Other co-morbidities linked to drug use

Cocaine-atropine combination

Between November 2004 and May 2005, 19 validated cases and 7 suspect ones (namely a total of 26 cases) of intoxication, following a sniffed or injected use of powder containing a cocaine-atropine combination³⁰, have been detected in 5 French regions: North-Pas-de-Calais, Lorraine, Île-de-France, Franche-Comté, and Midi-Pyrénées. Similar intoxication cases have also been reported in the Netherlands, Italy, and Belgium between November and December 2004 (OFDT, 2004c).

Identifying those cases immediately triggered a health alert and a press release from the DGS (General Health Department) on December 17th, 2004, taken over by national papers (all in all, two alerts have been set off by DGS). Whether such combination has turned up accidentally or deliberately in the market is not known. Between 1999 and 2004, among the 147 cocaine samples analyzed by the SINTES system (an amount of 147), there has not been a single one containing atropine.

Individuals having used cocaine with heavy atropine contents have shown acute psychiatric and/or neurological symptoms.

Powder samples of cocaine-atropine do not present any characteristics enabling to be visible to the naked eye. The proportion of atropine content varies from 12 to 70%. A 150 mg “rail” of powder containing 33% of atropine equals 50 mg of atropine. When the resorption level at the nasal mucous membrane is not known, the correlation from 1 to 50 between the maximum therapeutic dose intravenously injected and the dose contained in such a “rail” leads undoubtedly to an atropine overdose, and therefore to a wide range of symptoms in connection with the vegetative nervous system. An intoxication may also cause restlessness with mental confusion and hallucinations, and even a respiratory depression (OFDT, 2004c).

Driving

Results from the Road Safety Survey on “Narcotics and fatal road accidents” (SAM)

In the absence of reliable epidemiological data relating to the impact of a narcotic use on road accidents, the Law pertaining to Road Safety of June 18th 1999 and its Enforcement Decree of August 27th 2001 have established systematic investigations of such substances (cannabis and its by-products, opiates, cocaine and amphetamines) among drivers involved in instantaneously fatal road accidents. That study, financed by the Ministry of Health and

³⁰ Molecule used in medicine notably for treating some specific heart conditions.

coordinated by the OFDT, was given to a group of multidisciplinary researchers³¹ (Laumont and al, 2005; OFDT, 2005b).

From October 1st 2001 until September 30th 2003, all drivers so involved had to be submitted to urinary screening tests. Should it prove impossible or should the test be positive, a blood sample was taken in order to search for narcotics³². Those results were added to usual police breath-tests in search of alcohol contents exceeding the licit upper limit of 0.5g per blood litre. More than 10,000 tests were collected, involving about 17,000 drivers. After discarding all incomplete procedures, the study kept 10,748 drivers involved in 7,458 mortal accidents.

Among the 10,748 drivers involved in fatal accidents, 853 have tested positive for narcotics (7.9%), of which 751 for cannabis (7.0% from the whole). Through lack of enough drivers testing positive, the effects from amphetamines, cocaine, and heroine could not have been satisfactorily analyzed (50 drivers positive for amphetamines, 22 for cocaine, and 91 for opiates, alone or combined with another substance). Additional studies prove therefore necessary.

Among the 751 drivers testing positive for cannabis, 40% also present an alcohol level exceeding the legal one. Even if it is not its major purpose, such a survey can nevertheless suggest an estimate of cannabis prevalence (beyond the detection upper limit of 1 ng/ml) of 2.9% among the whole “current” drivers.

When comparing responsible drivers with non-responsible ones, and accounting for some confusion factors (other narcotics, alcohol, age, type of vehicle, time of the accident, etc.) that study shows that drivers under the influence of cannabis (all THC concentrations taken into account) run 1.8 times more risks (CI at 95%: [1.4-2.2] to be responsible for fatal accidents than drivers testing negative.

Besides the survey enables for the first time to highlight the fact that the responsibility risk increases along with THC concentration. Such a dose-effect pleads in favour of an actual causal correlation. Indeed the risk to be responsible for one’s own accident goes from 1.6, if the driver ranks below the level of 1 ng/ml, to 2.1, if (s)he ranks above 5 ng/ml.

All concentrations taken into account, the ratio of fatal accidents due to cannabis positive tests stands around 2.5% (CI at 95%: [1.5-3.5]). The annual number of victims directly attributable to the over-risk of responsibility connected with driving on cannabis would stand around 180 killed individuals, out of a basis of 6,000 fatal accidents per year.

Otherwise the survey brings to light the fact that, even if the driver is not responsible, his (her) risk to die is increasing along with his (her) cannabis positivity³³. The yearly number of victims due to that specific exposure among drivers on cannabis would be around 50 killed individuals. Therefore the yearly number of victims attributable to cannabis, either directly for a more frequent accident responsibility or indirectly for a higher exposure, would be around 230 killed individuals ([Table 23](#)).

Such figures may be compared with those relating to alcohol use, issuing from the same survey and calculated with the same methodologies. As far as alcohol is concerned, 2,251 drivers involved in a mortal accident, namely 20.9% from the whole (7% for cannabis), test higher than the legal alcohol level. The estimate of alcohol prevalence among “current” drivers stands at 2.7% (2.9% for cannabis), a result that matches the one produced by other surveys.

³¹ SAM Group: Ceesar, LAB PSA Peugeot-Citroën/Renault, Inserm, INRETS et OFDT; under the scientific authority of Bernard Laumont (INRETS/UCBL/InVS UMRESTTE).

³² Urinary screening test was regarded as positive for amphetamines from a urine concentration of 1 000 ng/ml, for cocaine or opiates from 300 ng/ml, and for cannabis from 50 ng/ml en Δ^9 acid tetrahydrocannabinol (THC-COOH). Blood dosage was considered positive for amphetamines or cocaine from a blood concentration of 50 ng/ml, of 20 ng/ml for opiates, and of 1 ng/ml de Δ^9 tetrahydrocannabinol (THC) for cannabis.

³³ Subject to a theory of causal correlation yet to be extended: being under the influence of cannabis could trigger risk behaviours such as not fastening one’s seat belt.

When it comes to the responsibility in fatal accidents, drivers under the influence of alcohol (all levels taken into account) run 8.5 times more risks to be accountable for them than drivers testing negative (CI at 95 %: [7.1-10.1] ; as for cannabis, the over-risk ranks at 1.8) (Table 23). All in all, out of a basis of 6,000 mortal accidents per year, 2,270 of them would be attributable to alcohol.

Table 23: Risk to be responsible for a fatal road accident (Odds Ratio and 95% Confidence Interval), and deaths due to cannabis and alcohol

Blood concentrations	Odds ratio (OR)	95 % CI	Yearly deaths due to
Cannabis (ng/ml) ⁽¹⁾			
THC ≥ 0 ng/ml	1.8	[1.4-2.2]	230
Alcohol (g/l) ⁽²⁾			
Negative	-	-	
< 0.5	2.7	[2.1-3.4]	
0.5-0.8	6.3	[3.7-10.6]	
0.8-1.2	7.6	[4.75-12.0]	
1.2-2.0	13.1	[9.1-19.0]	
≥ 2.0	39.2	[22.6-68.3]	
Together	8.5	[7.1-10.1]	2,270

(1) OR adjusted to alcohol, age, type of vehicle, and time of the accident

(2) OR adjusted to cannabis, age, type of vehicle, and time of the accident

Source: SAM Survey on "Narcotics and fatal road accidents", 2005.

Other information on driving under the influence of narcotics

The first screening tests operated on drivers have occurred from 2003 second half-year onwards, such controls being only performed by the National police (OFDT, 2005a). In 2004 that device has been extended to all police forces (National police, Gendarmerie, Paris Police authorities).

When screening proves positive there is no information available on the type of substance accountable for it. Setting up such a control device raises the issue of tools to be used for screening narcotics (See Section 7).

In 2003, out of more than 2,000 screening tests carried out, 16% have proved positive, vs. 22% in 2004 out of a total of 15,900 (Table 24) (DLPAJ/CSR, 2005). The positivity rate varies throughout both years and according to screening circumstances (suspicion, accident, road offence). We must still wait for some years until we have a clear idea on the consistency of such figures, all the more so since the reasons of a control for "use suspicion" have remained vague so far.

Table 24: Screening for narcotic use on the road and positivity, 2003-2004

	2003 ⁽¹⁾		2004 ⁽²⁾	
	Number	% of positives	Number	% of positives
Screening performed	2,138	16 %	15,905	21. %
<i>in case of:</i>				
Suspicion about narcotic use	59	44.1%	5,144	36,5 %
Accident (mortal, physical injury, material damage)	1,415	12.4%	9,563	11.0%
Driving offence	661	21.6%	198	45.7%

(1) Carried out only between July and December 2003 by the National Police.

(2) Carried out throughout the year by all police forces (National Police and Gendarmerie, Paris Police authorities).

Source: DLPAJ/CSR, Ministry of the Interior and The Town and Country Planning.

According to the survey carried out among frequent cannabis users, one user out of three (35%) acknowledges having often driven a vehicle within 4 hours following a cannabis intake. Another third (36%) of them declare having sometimes driven during the year, after smoking (Bello *et al.*, 2005b).

Cannabis and pregnancy

A French research team has proved the regulating role of receptors to cannabinoids in the brain development of foetus, and therefore suggests that cannabis use during pregnancy could delay brain development *in utero*.

THC owes its psychotropic action to its interaction with receptors to Type 1 cannabinoids (CB1). If CB1 receptors are too activated, under the influence of too high a quantity of cannabinoids, the brake effect is strong and the activity of neuronal networks dramatically slows down even stops. Cannabis use is then likely to powerfully decrease foetal brain activity, and consequently to damage the right development of brain. On the other hand we do not know of a threshold effect, genetic conditions, or a critical period throughout gestation (Bernard *et al.*, 2005 ; INSERM, 2005).

7. Responses to health correlates and consequences

Responses to health correlates and consequences: general context

Prevention of drug-related deaths: France does not have a national policy or specific interventions to reduce overdoses. Access to substitution treatments, together with the risk-reduction system are, in practice, indirect means of preventing deaths linked to opiate use. See [Structured questionnaire no. 29] for more details.

Prevention and treatment of drug-related infectious diseases:

The risk-reduction policy is defined as all the measures implemented to prevent infection by the AIDS and hepatitis viruses and also the problems and complications resulting from drug use and the search for drugs. It principally involves preventing the health complications linked to intravenous injection and injection of products made in poor hygiene conditions (abscess, overdoses, septicaemia).

In France, the system relies on prevention actions which aim to facilitate access to sterile injection equipment and to spread publicity about prevention, together with access to screening among the high-risk population.

The actions are mostly developed by associations external to the specialised system with support from the State or local communities.

The system is based on the following complementary actions:

- free sale of syringes in pharmacies (sold without prescription since 1987);
- dispensing machines delivering Stéribox® injection kits (225 in total in 2002) or collecting used syringes (153 in 2002) ;
- community needle and syringe programmes (NSP): 118 in 2001;
- drop-in centres or contact centres for drug users (40 in 2001);

Overall, the risk-reduction system covers the greater part of French territory (87 departments covered).

Screening is, theoretically, facilitated by the existence of screening centres which are anonymous and free of charge (Anonymous free screening centre, CDAG), of which there are 386 outside prisons and 109 in prisons (in 2002). There is a plan to control hepatitis B and C (2002-2005), the principal objectives of which are: to reduce transmissions, to improve screening, the treatment system and access to treatment, to intensify clinical research, monitoring and evaluation. Prevention of infections through sniffing is controversial in France, but several associations are involved with it, although with little support from the State.

[Structured questionnaire no. 23] on harm reduction measures to prevent infectious diseases among drug users provides an overall view of the political strategies selected, the interventions which result from them and which are effectively introduced in France.

The places where syringes are available, together with the estimate of the quantities distributed, are given in [Standard Table no. 10].

Interventions linked to psychiatric co-morbidities: there is strictly-speaking no service specialising in the treatment of drug users presenting associated psychiatric pathologies; some psychiatric hospitals have, over the last few years, developed a system for treating drug addicts but they are still rare. Three different circulars issued since 1998 by the Directorate General for Health (DGS) have had the same objective of improving treatment and have recommended increased cooperation between the services involved (CSST, hospital psychiatric service etc.) but collaboration remains sporadic (Wieviorka, 2003).

7.1 Prevention of drug-related deaths

NO NEW INFORMATION AVAILABLE

7.2 Prevention and treatment of drug-related infectious diseases

In March 2004 a seminar was arranged by the INPES (National Institute for Health, Education, and Prevention), in collaboration with the MILDT and the DGS, in order to detect the most efficient solutions for reducing hepatitis incidence in France among drug users (DUs) population.

The purpose set up the seminar was to attempt to give answers to some questions: Which steps to take before injection? How to improve community-based prevention? How to get in touch with most marginalized individuals? Contributors also tried to understand HCV knowledge and perceptions among DUs and health professionals.

Propositions were made in terms of information, training, screening, cross-disciplinary care and action. In particular:

- To make DUs partners in developing and evaluating actions, tools, and messages, as well as to support the association-based actions promoted by users and patients;
- To adjust actions, tools, and messages to the specificities of UD subgroups;
- To shape access to treatment and social rights as bridges for social reintegration even ways out from drug addiction;
- To update and validate regularly the scientific content of messages;
- To inform population of Hepatitis C “weight”, and communicate positive messages;
- To supply training both for contributors and peers among UD community;
- To promote treatment networks among doctors and nurses;
- To supply therapeutic and social support.

Besides suggestions put forward, people taking part in the seminar have called attention to the fact that some effort is mostly required from all contributors in order to build and set up innovative actions (INPES, 2004).

7.3 Interventions related to psychiatric co-morbidities

NO NEW INFORMATION AVAILABLE

7.4 Interventions related to other health correlates and consequences

NO NEW INFORMATION AVAILABLE

8. Social correlates and consequences

Social correlates and consequences: general context

Social exclusion: the social and economic situation of drug users may be deduced from the socio-economic characteristics recorded as they pass through the reception centres (CSST's or low threshold facilities). Their level of vulnerability varies depending on the type of facility attended. The users who come to low threshold facilities exhibit greater social exclusion than those encountered in the CSST's: more unemployed people (50% of patients at low threshold facilities live on welfare assistance, compared to around 30% at the CSST's), more insecure accommodation situation (40% at low threshold facilities compared to 30% at CSST's), more single people and fewer parents with dependent children.

Looking overall at the careers, way of life and risk ratio of users (in particular of heroin) enables us to understand the processes of insecurity at work (economic and social instability, lack of schooling, lessening of responsibilities) associated with the onset of drug addiction problems in the life of the individual. For Bouhnik and Touzé (1996), instability of living conditions of users associated with repression and repeated imprisonment contribute to the growth of at-risk behaviours. According to Jamouille (2001), the users must deal with several forms of insecurity: economic, social and civic, health and psychological.

Among the homeless, drug addiction generally comes before the individual's social exclusion (Dabit and Ducrot, 1999; Declerck and Henry, 1996; La Rosa, 1998). On the other hand, exclusion engenders a sharp feeling of loss of social position which is likely to push an individual towards addiction since they have not deliberately chosen marginality. But the substances can also be a way of enduring the violence generated by life on the street: *"the use of psychoactive products appears to be a means of enduring difficulties and this use is itself the cause of additional difficulties because it leads to premature insecurity"* (Joubert, 2003).

Drug-related offences and crime: according to the current laws on narcotics use in France, any person who uses and/or posses and/or deals in these substances lays himself or herself open to criminal sanctions which could even mean imprisonment. The user may, for example, be arrested, which may or may not be followed by sentencing, and possibly imprisonment.

Crime data on offences against the narcotics laws (ILS) offer the advantage that they are properly kept, historic and easily accessible. On the other hand, they do not give a complete picture of how offences are dealt with, ever since arrest until conviction, and possibly sentence achievement.

Arrests for ILS are classified in two major categories: simple use and trafficking (broken down into use and trafficking, local trafficking and international trafficking) [Standard Table no. 11].

Sentences recorded in the national police records (CJN) register judgements made against users who have come before the court. A sentence may cover several offences but, conventionally, sentences are shown as for the principal offence. The statistical categories used are as follows: illicit use of narcotics, assisting drug use, possession/procuring, manufacture/use/carrying, supplying, import/export and other offences against the narcotics laws.

Since 2003, driving under the influence of substances or plants classified as narcotics has been an offence (law no. 2003-87 of 3 February 2003, NOR: JUSX0205970L). The offence is liable to 2 years' imprisonment and a € 5,000 fine for single use of narcotics and the penalty is greater when use of alcohol at the same time has been noted. Screening is compulsory for all drivers involved in a fatal accident and is automatic if there is suspected use in the case of personal injury accidents. Random checks may also be carried out.

Drug use in prison [Standard Table no. 12]: A survey carried out in 2003 showed that 33% of those entering prison declared prolonged and regular use of drugs (illicit drugs and medicines diverted from their normal use) during the year preceding imprisonment (Mouquet, 2005); in the general population, regular users of illicit drugs represented in 2002 6% of those aged 18 to 25 and 2% of those aged 26 to 44 (Beck *et al.*, 2002). These data clearly show that drug users are over-represented in comparison to the general population.

The existing studies show that all products smoked, sniffed, injected or swallowed before imprisonment are still used, but to a lesser extent, during imprisonment (Rotily, 2000). In addition, more accessible use, such as use of medicines, have developed within the prison environment. Generally speaking, there is a changeover from use of illicit, rare drugs towards medicines (Stankoff and Dherot, 2000).

These uses of narcotics, whether begun or continued in prison, have grave effects on the state of health of those involved: serious abscesses, risk of accidents where medicines are associated with other products, severe withdrawal symptoms of greater duration, appearance or intensification of psychological or psychiatric pathologies. In addition, prisoners constitute a population which, from the point of view of the health and social consequences of drug use, has increased risk factors. The low level of access to treatment for this population and, more fundamentally, the situations of insecurity and exclusion which they have often been faced with before imprisonment (absence of a fixed home or of welfare assistance) are all factors in the prevalence of at-risk use among those entering prison.

Injection seems to be widely-practised within this vulnerable population, although the number of intravenous drug users seems to be decreasing: in 1997 6.2% of prison entrants declared that they had used drugs intravenously in the course of the year preceding imprisonment (Mouquet *et al.*, 1999); in 2003 only 2.6% of entrants would acknowledge an injection practice (Mouquet, 2005). According to the surveys, 60 to 80% of these stop injecting when they enter prison. However, those who continue, even if they reduce the frequency of their injections, seem to be greater injectors, and more often affected by HIV or HCV, so that the risks of infection are great if there is sharing of equipment, unprotected sex or tattooing.

Finally, prisoners seem to be more affected by infectious diseases than those in the general population. The most recent data can be used to estimate that the prevalence of HIV in the prison environment is 3 to 4 times greater than outside prison and that of HCV 4 to 5 times greater. However the prevalence of HIV inside as well as outside prison has declined, although that of hepatitis C is growing considerably.

Social cost of drugs: the latest estimate available dates from 2000 and is based on 1995 figures (Kopp and Fenoglio, 2000). Excluding the cost of use and considering only illicit drugs, this cost is 2,0352 million Euros, which is equivalent to 0.16% of the national GDP.

The social cost of drugs is spread between: losses of income and production (45.7%), expenditure by the public authorities (36.3%) and expenditure on health (11.4%); mainly the cost resulting from treatment of AIDS and the costs relating to Subutex®), losses of compulsory insurance contributions and other costs borne by private agents.

8.1 Social exclusion

NO NEW INFORMATION AVAILABLE

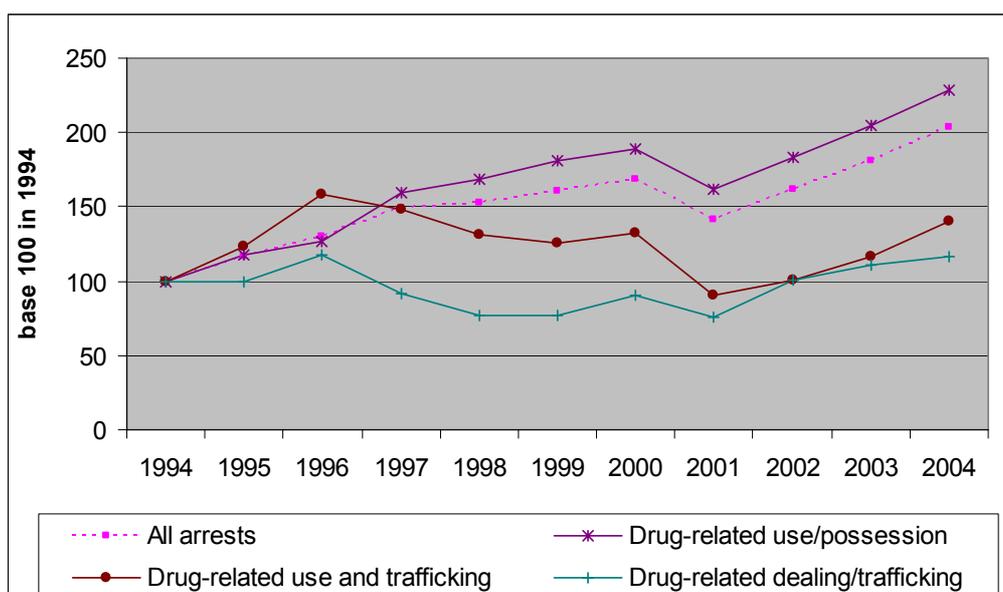
8.2 Drug-related offences and crime

Arrests for drug-law offences

In 2004 the police, Gendarmerie, and customs have operated 121,254 arrests for drug-law offences (DOs), namely 12% as more as in 2003 (and 26% as more as in 2002) (Office central pour la répression du trafic illicite des stupéfiants (OCRTIS), 2005). Among various categories of arrests, all are on the rise when compared with the previous year, and most particularly arrests for use and arrests for use and trafficking (respectively +11.7% and +21% between 2003 and 2004) (Graph 5).

Drug use remains the major reason for arrests: 101,278 procedures, namely 84% of arrests for DOs in 2004, a share similar to the one covering the last four years.

Graph 5: Evolution in categories of arrest, 1994-2004



Interpretation: the evolution of police questioning categories is shown here with 1994 as a benchmark (base 100); yearly evolutions are therefore calculated with a 100 index in 1994: any figure under 100 conveys a decrease in comparison with the base year while any figure over 100 points to a rise.

Source: FNAILS, OCRTIS.

There are 11,599 arrests for drug use and trafficking, the second reason for arrest (10% of all arrests for DOs). Arrests for trafficking divide up as follows: 1,336 arrests for international trafficking, and 7,043 for local one (that is 7% of the whole arrests for DOs). Following the trends from last years onwards, arrests for drug use mostly concern cannabis yet the influence of such substance is less significant among arrests for use and trafficking and trafficking.

Table 25: Arrests for DOs per substance, 2004

	Use	% lined up	Use-dealing	% lined up	Trafficking	% lined up	Total	% lined up
Cannabis	91,705	90.5%	9,017	77.7%	4,653	55.5%	10,5375	86.9%
Heroin	3,730	3.7%	918	7.9%	987	11.8%	5,635	4.6%
Cocaine	2,458	2.4%	698	6.0%	1,786	21.3%	4,942	4.1%
Crack	744	0.7%	151	1.3%	313	3.7%	1,208	1.0%
Ecstasy	1,659	1.6%	542	4.7%	471	5.6%	2,672	2.2%
Medicines ⁽¹⁾	324	0.3%	179	1.5%	85	1.0%	588	0.5%
Others	658	0.6%	94	0.8%	84	1.0%	836	0.7%
Total	10,1278	100%	11,599	100%	8,379	100%	12,1256	100%

(1) Subutex®, methadone, skenan®, moscontin, fentanil, rohypnol, valium....

Source: FNAILS, OCRTIS.

As for substances, 2004 noticeable evolutions from the year before are the following ones:

- Increase of arrests for medicines (+65 % for use, +126 % for use and trafficking, +86 % pour trafficking). Such a category includes Subutex® and methadone, as well as Skenan®, moscontin, fentanil, rohypnol, barbiturates or benzodiazepines;
- Significant drop among all categories of DOs for crack ;
- Increase of arrests for cocaine use and trafficking (+50 %);
- Increase of questionings for ecstasy drug use and trafficking and for trafficking (respectively +31 % and +22 %).

Among users arrested in 2004, the medium age proves fairly even since 1996 (around 23 years-old), as well as the share of minors involved in cases (2 to 3% for individuals under 15, 10% for 16-17 year-olds among whole individuals questioned). The user's medium age vary according to the substance at stake: 22.5 years-old in 2004 for cannabis users, 24 for ecstasy ones, 29 cocaine and heroin ones, 33.6 for crack ones. The most covered socio-professional categories are employees (12% from all individuals questioned), workers (22%), students and secondary school pupils (27%), individuals having no occupation or whose occupation is unspecified (34%). As with the medium age, disparities can be observed in the distribution according to the substance at stake for questioning.

Comparing the characteristics of users questioned for cannabis with those of declared cannabis users in general population surveys brings to light some significant disparities: about age, gender, as well as socioeconomic conditions (Peretti-Watel *et al.*, 2004). The users taken in for questioning are younger, males, and more often on the dole or with no occupation than cannabis users from surveys. For example: among users arrested in 1999, 93.1% are males vs. 67% among users during the year; the gap between both figures is similar for year 2001.

While general population surveys exemplify the diversity of cannabis users, police statistics prove that the users mostly open to questioning are far from draining such diversity. Arrest data relating to cannabis are therefore not representative of cannabis users but only echo the activities and action strategy of law enforcement services.

Sentences for drug law offences

According to temporary figures available so far (SDSED) all sentences for DOs delivered in 2003 amount to 26,796, namely a 20% increase from those delivered in 2002. Among offence categories, sentences due to drug law offences register the highest rise.

Table 26: Sentences for DOs (major offence) per offence category, 2001-2002

	2002 (revised)	2003 (temporary)	Distribution in 2003 (%)	Evolution 2002-2003 (%)
Whole offences	376,115	411,373		9.4%
Whole DOs	22,135	26,796	100.0%	21.1%
Illicit narcotic use	4,707	6,338	23.7%	34.7%
Possession, purchase	8,942	10,909	40.7%	22.0%
Supply	2,241	1,911	7.1%	-14.7%
Trade, use, transport	4,284	5,497	20.5%	28.3%
Trafficking (importing-exporting)	1,500	2,017	7.5%	34.5%
Encouraging other people to use	54	55	0.2%	1.9%
Other DOs	49	69	0.3%	40.8%

Note: figures are revised in between years and remain provisional for the current year (hence the disparities from the abstracts asked of the Ministry Statistical Service).

Source: National Police Record Office (SDSED- Ministry of Justice).

Among sentences ordered, 6,338 of them relate to illicit use (vs. 4,803 on the previous year). Proportionately speaking this stands as the DO category in which the increase of convictions is the most significant. Such a rise proves all the more noteworthy as it interrupts a downward evolution begun in 2000.

As for sentences themselves an increase of imprisonments without remission can be observed (whereas they registered a backward tendency) to the detriment of alternative

sentences, yet without the possibility to assess the impact of quick procedures upon those evolutions³⁴.

Incarcerations for drug-related offences

The new version of the national register of prisoners came into force in 2003. The 2003 figures are not therefore comparable to those for previous years.

In 2003, 9,659 people were imprisoned for an offence against the narcotics laws³⁴, either alone or in association, out of a total of almost 80,000 people sent to prison. The most-often selected offence was supply/transportation (present in 3,081 cases of imprisonment, i.e. 32% of those for offences against the narcotics laws), followed by use of narcotics (selected for 2,652 people imprisoned in the course of the year, i.e. 27.5% of cases of imprisonment for offences against the narcotics laws).

In 2004 10,708 persons entered prison for an offence against the narcotics laws, representing around 12% of all entrants (Table 27).

At 1st January 2004 there were 4,412 people in prison for an offence against the narcotics laws as their main offence. At 1st January 2005 the figure was 5,262.

Table 27 : Imprisonment for narcotics offences, 2003-2004

	2003		2004	
	Number	Distribution	Number	Distribution
Use	2 652	27,5 %	3 051	28,5 %
Transferring	619	6,4 %	576	5,4 %
Possession	1 132	11,7 %	1 230	11,5 %
Trafficking	371	3,8 %	334	3,1 %
Help to use	12	0,1 %	17	0,2 %
Laundering	48	0,5 %	51	0,5 %
Supply/transportation	3 081	31,9 %	3 742	34,9 %
« Drug procuring »	57	0,6 %	41	0,4 %
Possession of goods from narcotics offences	7	0,1 %	6	0,1 %
Possession of money from narcotics offences	1	0,0 %	1	0,0 %
Others narcotics offences	128	1,3 %	235	2,2 %
Narcotics offences without specification	1 551	16,1 %	1 424	13,3 %
All narcotics offences	9 659	12,1 %	10 708	12,4 %
All offences	79 921		86 068	

Note : data present in the table correspond to entrants between 1st January to 31th December with an offence against the narcotics law (rank 1).

Source: National register of prisoners (PMJ1 - Ministry of Justice)

Chemical submission

The national follow-up survey for cases of chemical submission³⁵ aimed at detecting the substances used, defining the circumstances of attacks, as well as assailants' modus operandi, and eventually at evaluating clinical consequences among victims (AFSSAPS and CEIP de Paris, 2005).

³⁴ The Ministry of Justice Statistics Department no long publishes sentence data per type of trial, whereas the ratio of sentences delivered in the absence of the convict (sentence in absentia or to be notified after due hearing of the parties) is an essential element to assess evolutions, particularly when it comes to sentence patterns. The increase of convictions, notably for imprisonment, may be the predictable and combined consequence from the failure of alternative measures and the use of quick trial proceedings.

³⁵ Chemical submission is defined as administering one or many psychoactive substances without the victim's knowledge, for criminal purposes (rapes, acts of paedophilia) or offending ones (intentional acts of violence, thefts).

Among the 258 cases surveyed between July 2003 and March 2005, 119 can be regarded as actual cases of chemical submission. The events occur at the victim's or the assailant's place (48%), or in a recreational setting (22%). Females as more often victims than males, and nearly one female out of six (13%) is still under age. During such physical attacks, they have been more frequently assaulted sexually, and males generally robbed.

The most commonly used substances in those cases are tranquillizers and hypnotics (benzodiazepine family, 60% of cases), generally added up to alcoholic or soft drinks; anaesthetics and notably GHB — usually labelled as “rape drug” — are seldom used (only 6 cases for GHB) (Table 28). The deliberate use of alcohol (49 %) and cannabis (36 %), frequently found out among young individuals, is a significant factor of exposure and strengthen the sedative and disinhibiting effects from substances administered by assailants.

That survey will be carried out again in 2005.

Table 28: Families of substances detected in cases of chemical submission, 2003-2005

Family	Most frequent substances ⁽¹⁾	Number of cases identified
Benzodiazepines	Clonazepam, Bromazepam, Oxazepam, others	100
Antihistamines / Sedatives	Doxylamine, Hydroxyzine, others	20
Analgesics	Dextropropoxyphene, others	9
Anaesthetics	GHB	9
Antidepressants		6
Varied substances	Quinidine	4
Medicinal substances	MDMA and by-products, amphetamines, cocaine	15

(1) non-exhaustive list

Source: (AFSSAPS and CEIP de Paris, 2005, p.10-12)

Driving

Refer again to Section 6 for the results from the epidemiological survey “Narcotics and Fatal Road Accidents” (SAM).

Screening for narcotic use on the road: which tools for it?

Although screening for narcotic use on the road is granted by the Law of February 3rd 2003, its enforcement is not that easy, the major issue being the use of reliable and manageable tests for operating by the roadside. At the present time screening is performed by urinary test, an awkward procedure as it particularly needs doctor attendance on the spot, and such test must afterwards be validated by a blood one (in case of positive urinary test, the individual is then taken to a hospital for a blood test). A urinary test does not actually make possible an accurate dating of cannabis use, and only a subsequent blood test enables specifying whether the driver was under narcotic influence when being tested.

Adopting a salivary screening test to operate controls is being debated as the urinary test proves barely handy to be performed by the police on drivers and quite expensive. Yet in the specific case of cannabis, a salivary screening test is not reliable (while detecting heroin, cocaine, or ecstasy with that same test does raise no issue). “*Even if the toxicologist community is quite supportive of salivary screening, generalizing such tests is untimely and does not certainly tally with scientific facts [...]. That test proves effective only in 10 to 15% of cases. It is disastrous. If such tests are brought into general use, cannabis users will quickly know that these devices do not work*”. (Kintz, 2005).

For the time being two pilot regions operate control with various salivary tests (Île-de-France and Centre); a full assessment of those experiences should be available by the end of 2005.

Meanwhile the AFSSAPS should give its conclusions on those tests, a necessary condition for validating their use on the road.

A salivary test is nevertheless expensive: between € 15 and € 20. Besides for each blood test performed for validating a positive case, the government is charged € 216.

Offences recorded for driving after using narcotics

The new legislation has been passed in 2003. During 2004 the police screening activities on the road have been performed throughout the year, and that accounts for the significant disparity among offences recorded in between both years (*Refer to Section 6.4 for knowing the number of roadside screening tests carried out*).

Another year is needed yet to have a better knowledge of the impact from that new legislation, and what is more of its significance. In the absence of simple screening tools (see above), it seems difficult to consider a very important increase in the number of recorded offences when compared with 2004 figures.

While more than 2,000 offences have been recorded in 2004, we must also bear in mind that during the same period the government has particularly focused its messages on that new parliamentary scheme, and emphasized repression on “risk” driving (alcohol, narcotics, speed).

Table 29: Number and distribution of offences recorded for driving after using narcotics, 2003-2004

	2003 ⁽¹⁾		2004 ⁽²⁾	
	Number	Distribution	Number	Distribution
Driving after using narcotics	70	24.7 %	1,577	71.1 %
Drunk driving after using narcotics	208	73.5 %	528	23.8 %
Refusal to submit oneself to narcotic screening	5	1.8 %	112	5.1 %
Total	283	100 %	2,217	100 %

(1) Screening for driving offences only carried out between July and December 2003.

(2) Screening carried out throughout the year by all police forces (National Police and Gendarmerie, Paris Police authorities).

Source: DLPAJ/CSR, Ministry of the Interior and the Town and Country Planning.

8.3 Use in prison

First epidemiological survey on mental health in prison

Faced with the insufficiency of national epidemiological data, the Ministry of Health has decided in collaboration with the Ministry of Justice to carry out a three-step survey pertaining to the mental health of detained individuals. The first step includes a cross-disciplinary whose purpose was to evaluate the prevalence of mental disorders in incarcerated population: it was based on a representative sample of 1,000 imprisoned individuals, among which 800 males selected by drawing lots in 23 prisons from Metropolitan France, questioned between July 2003 and September 2004 through regional SMPRs (Regional hospital medico-psychological centres) (Fassilard and Rouillon, 2004). Psychiatric symptoms have been detected among 40% of them, addictive and anxiety troubles essentially. One fourth of prisoners suffer from mental disorders due to the use of toxic substances.

Each interviews has been conducted by psychiatrists using the tool for addiction epidemiological evaluation or “*Mini international neuropsychiatric interview (Mini)*”, before proceeding with a second clinical interview.

Therefore, among the sample questioned:

- 8% of prisoners show an abuse or an addiction to illicit substances;

- 31% of them reveal an alcohol abuse or addiction.

Before entering prison, 6% of detained individuals in Metropolitan France have been followed by the fight against drug-addiction scheme and 8% of them by the one relating to alcohol addiction.

Supported by a previous epidemiological survey among 2,300 prison entrants in June 2001, that study has estimated at 55% the share of individuals suffering at least from one psychiatric trouble of a more or less significance. In that suffering population, more than half would present addictive troubles (alcohol, drugs, or others). On the basis of 799 male prisoners surveyed in Metropolitan France, the current major prevalences rank high though yet to be validated by a survey on first-time prisoners. Estimates in male incarcerated population establish therefore as follows:

- Depression symptoms: 40%
- General anxiety: 33%
- Traumatic neurosis: 20%
- Agoraphobia: 17%
- Schizophrenia: 7%
- Paranoia, chronic hallucinatory psychosis: 7%.

Health of individuals admitted to prison

The survey on prison entrants' health was carried out in 1997, then renewed in 2003 (Mouquet, 2005). More than 6,000 files containing information on risk factors for health and pathologies recorded among entrants have been collected (data representative of the population of prison entrants). The methodology adopted in 2003 being similar to the one from 1997, the results from both surveys can be compared with each other.

When offenders are admitted to prison, their general health conditions are judged mostly satisfactory (80%) by doctors. Six percent of entrants have been prescribed a consultation specialized in alcoholology or psychiatry for a motive relating to alcohol addiction (vs. 4.0% in 1997); 6.3% have been prescribed a drug addiction or psychiatry consultation for addiction issues (vs. 6.7 % in 1997).

More than three entrants out of ten acknowledge an alcohol abuse³⁶ (Table 30). One third of detained individuals declare a long-lasting and regular use of illicit drugs, mostly cannabis, throughout the 12 months prior to their incarcerations. Between 1997 and 2003 the proportion of entrants declaring a regular cannabis use has been increasing, while the one including opiate or cocaine users has been decreasing, as well as polydrug use. Injecting drugs is becoming infrequent.

On their admission to prison, about 7% of entrants declare being granted a substitution treatment: Subutex® in 8 cases out of 10 (Table 30).

The prevalence of chronic infectious diseases has declined between 1997 and 2003, yet such strictly declarative results remain quite flimsy. While 6.5% of entrants would declare a positive serology for HIV, Hepatitis B or C in 1997, such a ratio reaches 4.2% in 2003. Entrants having injected themselves with a substance at least once in their lifetimes (6.5%) are more numerous to have undergone screening tests for AIDS or Hepatitis, as well as declaring positive results³⁷.

Among minors³⁸ admitted to prison, 4 out of 10 declare a regular use of illicit drugs, mostly cannabis, throughout the 12 months prior to their detention. The increase of cannabis use

³⁶ Described as over or equalling 5 glasses a day for males, and 3 glasses a day for females, in case of regular use; and over or equalling 5 successive glasses at least once a month, in case of intermittent use.

³⁷ Precise prevalences are not available in that publication.

³⁸ Incarceration is quite uncommon before 15 years-old; most of minors entering prison are 17.

observed between both surveys (from about 25% to about 38%) stands for a trend also recorded in population. The regular use of other substances (opiates, stimulants) is comparatively rare, and relates to 2% of entrants under age. Only 1% acknowledge having already injected themselves, and none of them declare being HIV, HBV or HCV positive.

Drug addiction prevalence among female entrants is lower in 2003 than in 1997 (respectively 19% and 26%). As in general population females admitted to prison declare a lower use of psychoactive substances when compared with males. The regular use of illicit drugs during the 12 months prior to incarceration reaches 19% among females vs. 34% among males. On the other hand, when resorting to standardized rates methods, females entering prison use more than the ones from general population. Using those same rates makes possible to assert that, when compared with males admitted to prison:

- The regular use of illicit drugs is 1.3 times as low among female entrants;
- Females are less frequently polydrug users (rate of polydrug users 1.8 times as low as the one relating to males);
- The share of regular female users of cannabis is twice as low.

Female entrants are more affected than males by AIDS and Hepatitis B: female seroprevalence rates respectively reach 3.8% and 2% vs. 0.9% and 0.8% among males. On the other hand they acknowledge being HCV positive less often than males (2.6% vs. 3.2%).

Table 30: Uses of psychoactive substances and substitution treatment among prison entrants, 1997 and 2003

	1997	2003
Entrants declaring an alcohol abuse ⁽¹⁾	33,3 %	30,9 %
Entrants declaring a long-lasting and regular use of illicit drugs during last 12 months prior to incarceration ^{(2) (3)}	32,0 %	33,3 %
including:		
<i>Cannabis</i>	25,6 %	29,8 %
<i>Heroin, morphine or opium</i>	14,4 %	6,5 %
<i>Cocaine or crack</i>	8,9 %	7,7 %
<i>Medicines used on an addiction-related basis</i>	9,1 %	5,4 %
<i>Other substances (LSD, ecstasy, glues, solvents....)</i>	3,4 %	4,0 %
Entrants declaring a polydrug addiction ⁽⁴⁾	14,6 %	10,5 %
Entrant declaring a use of illicit drugs by injection		
At least once	11,8 %	6,5 %
During last 12 months	6,2 %	2,6 %
Entrants declaring a substitution treatment under way		
Methadone	0,6 %	1,5 %
Subutex®	6,3 %	6,0 %

(1) over or equalling 5 glasses a day for males, and 3 glasses a day for women, in case of regular use; and over or equalling 5 glasses in a row at least once a month, in case of intermittent use. In the 1997 Survey, the adopted definition was: over or equalling 5 glasses a day regardless of gender. (2) An entrant may use many substances. (3) Use of one substance at least. (4) Use of two substances at least.

Source: Survey "Health files of entrant from freedom condition" (Mouquet, 2005).

8.4 Social cost

NO NEW INFORMATION AVAILABLE

9. Responses to social correlates and consequences

Responses to social correlates and consequences: general context

Social integration: the harm reduction policy aims to reduce not only the health problems but also the social problems which are a feature of the drug user's career: isolation, living on the street, emotional, family and professional breakdown. Among the harm reduction facilities are the drop-in centres, which are places of contact for users and sleep-in centres, which offer emergency night accommodation for drug users in very vulnerable situations (4 in 2002). There are front-line teams whose purpose is to improve the treatment of drug users and also to be local mediators (4 in 2001). The drug users can also attend facilities which belong to the system for fighting exclusion: emergency sleeping accommodation, accommodation and rehabilitation centres (CHRS), day reception centres and mobile assistance teams.

Within the different facilities, social workers and special education teachers work with users to facilitate their rehabilitation.

See also the [Structured questionnaire no. 28] on social reintegration.

One of the objectives set by the substitution treatments, in addition to bringing dependent users to the treatment system, is to help with their social rehabilitation. Several surveys have shown the positive benefit after 6 months to 2 years of treatment of the individual: an improvement in registrations with the authorities, better professional involvement, improvement in housing conditions (Batel *et al.*, 2001 ; Bilal *et al.*, 2003; Calderon *et al.*, 2001; Duburcq *et al.*, 2000; Fhima *et al.*, 2001 ; Lavignasse *et al.*, 2002; Reynaud *et al.*, 1997).

Some surveys have also shown that the treatments distance users from crime and offending whatever the socio-demographic and economic characteristics of these users may be (Calderon *et al.*, 2001; Facy, 1999; Henrion, 1995).

Assistance to drug users in prison:

- prevention of infectious diseases: all prisoners, on their arrival at the prison, are offered a medical consultation in the outpatient consultation and treatment units (UCSA) with, in particular, screening for tuberculosis, voluntary, confidential screening for HIV infection and, more recently, hepatitis C, together with a vaccination against hepatitis B. The regional medico-psychological service teams (SMPR) are responsible for psychiatric treatment in 26 prisons (generally large) while the UCSA's are responsible for somatic treatment.

However, a report produced for the Ministry of Justice on reduction of risk of transmission of HIV and viral hepatitis in the prison environment says that "*actions for prevention of HIV infection, AIDS and hepatitis are not effective in all institutions*" (Rotily, 2000, p. 46). In the opinion of the author, three strategies in the risk-reduction policy need to be improved: informing and educating prisoners, the offer of screening (HIV, HCV) and vaccinations, and reduction of overpopulation and promiscuity in the prison environment.

- risk-reduction: injection equipment is not provided in prisons in France. It contravenes article D-273 of the criminal code of procedure which states that prisoners may not keep for their use any object, medicine or substance which may enable or facilitate a suicide, aggression or escape. A circular from the prison authorities in 1996 provided for free, regular distribution of bleach to prisoners.

There is no law which explicitly prohibits the practice of tattooing. In the same way the rules state that condoms must be provided, mainly in the UCSA's in prisons.

- registration for treatment and treatment of dependencies: of the 186 prisons in France, few are developing a specific system of treatment for drug addicts. There are drug addiction units in 16 remand prisons; Care Units for prison leavers (UPS) were set up in 7 prisons as an experiment in 1997 (2 closed in 2003); outpatient alcoholism treatment centres (CCAA) have been opened in only 3 prisons. There are 102 prison services for integration and probation (SPIP) which assist with social monitoring of prisoners and their integration on leaving prison; they arrange for social rehabilitation of drug addicts (some of whom have begun treatment while in prison) by directing them towards public or community partners.

The prescription of substitution medicines is theoretically possible in prison under the same conditions as outside, in order to initiate or continue treatment with methadone or Subutex®. All

prisons must, when a prisoner enters the establishment, offer substitution treatment or a withdrawal method to those who express a need for it (circular DGS/DH/DAP of 5 December 1996). The Ministry of Health has carried out four successive surveys on substitution treatments (March 1998, November 1999, December 2001 and February 2004) which seem to show that access to substitution treatments for prisoners who are heroin addicts is still, in spite of real progress, less easy than it is outside prison and thus even if the proportion of prisoners with a substitution treatment raised: 2% in 1998, 3.3% in 1999, 5.4% in 2001, and 6.6% in 2004. The rate of interruption of substitution treatments on entering prison has fallen appreciably, from 19% in 1999 to 5.5% in 2001.

It has been demonstrated that the number of imprisonments (or re-imprisonments) is lower among people who benefited, before or during imprisonment, from substitution treatment (Levasseur *et al.*, 2002; Rotily *et al.*, 2000).

Alternatives to prosecution and substitution orders

The priority granted by official texts (Law of December 31st, 1970) to health and social section in the fight against drugs implies to develop alternative legal responses. In 1993 the CDO device (*conventions départementales d'objectifs justice-santé*, Département Agreements on Objectives in Health and Justice) has been set up for improving combination between legal and health institutions, in order to favour health-including prosecutions (drug rehabilitation programme order, direction to a health and social facility).

The Ministry of Justice Circular Letter of June 17th, 1999 (NOR: JUSA9900148C) requested public prosecutors to favour the fight against local trafficking rather than the one against simple use, when taking legal action against the users arrested. Such orientations have been reasserted by the Ministry of Justice Circular Letter of April 8th, 2005 (NOR: JUS D 05-300061 C). The latter recommends an appropriate and diversified penal response when it comes to fighting against narcotic use, as well as a voluntarist criminal policy against all addictions and individuals whose proselytism, under cover of lawful activities, encourages the use narcotics or alcohol.

Social and personality surveys (of the individuals arrested) were to be used to enable the sentence to be personalised and an appropriate measure selected. The diversification of responses to crime was highlighted: treatment orders, discontinuation of proceedings with referral and conditional discontinuation of proceedings, for alternative measures; socio-educational legal controls with compulsory treatment and probation for pre-sentencing measures.

The prison service for integration and probation (SPIP) is responsible for monitoring sentences which were alternatives to imprisonment. The SPIP identified, at local level, and under the supervision of the Judge responsible for the execution of sentences (JAP), the social, medical or other facilities which would enable the compulsory treatment orders to be implemented.

In regard to treatment orders, an alternative measure particularly applicable to people arrested who had a dependency problem, the national trend is rather towards stagnation, in spite of numerous efforts to re-launch it through circulars (Guigou circular of 17 June 1999 in particular).

At a later stage in the criminal process, offenders against the narcotics law may benefit from a substitute sentence order instead of imprisonment or a fine: the substitute sentence may take the form of community service, a day-fine or other measure. National data are patchy in regard to this, in the sense that they do not make it possible to distinguish the proportion of these measures applied to simple users, for example. In addition, monitoring of these measures is implemented by individual establishments but there is no national summary of changes observed in the implementation of these measures (Warsmann, 2004).

9.1 Social integration

NO NEW INFORMATION AVAILABLE

9.2 Prevention of drug-related offences and crimes

Survey on health and social care for detained individuals revealing an addiction or an abuse of licit or illicit substances

That survey consists in assessing the enforcement of the Interministerial Memorandum of August 9th 2001, which aims at redefining orientations pertaining to the medical care of incarcerated individuals with addiction issues³⁹ (Obradovic, 2004; Obradovic, 2005).

The purpose was then to make a part estimate of a governmental device management two years after its enforcement. The survey has attempted to measure the progress of thought in each French départements, as well as bring out some trends about deficiencies and disparities in the medical care scheme for incarcerated individuals.

The DDASSs (Département Directorates for Health and Social Affairs) have been requested through a questionnaire: 92% of them have supplied data likely to be used. Therefore the information collected are not directly issuing from penal structures, but they deliver useful guidelines on medical practices, the progress and insufficiency of health devices in the prison context.

The process of local medical care protocols happens to have been fully started since half of French départements have a procedure organizing coordination between services involved in prison.

Unlike the Interministerial Note prerogatives, the detection of abuse or addiction situations is not systematic for each substance: only 60% of penal establishments use detection tools during entrants' medical examinations (among which the "mini-grade grid").

The supply of medical care is mostly satisfactory for specialized consultations in drug addictions (available in 9 prisons out of ten) and alcoholology (in 8 prisons out of 10), yet the requirements are partly met in terms of:

- Opiate substitution treatments: in that area the principle of equality of care with the outside world is dramatically upset. Obligations inherent to prison management as well as medical follow-up are the main reasons for it;
- Access to nicotinic substitutes: essentially for financial reasons;
- Setting up non smoking units (in 24% of prisons only);
- Medical treatment for alcohol addiction, despite indisputable progress yet not matching up the whole range of requirements, not to mention unacceptable waiting times;
- Accommodation for released individuals with addictive behaviours.

Difficulties observed are not only due to insufficient means for staff and financing but also partly to professional practices themselves, when the latter have not evolved enough (reluctance to substitution which is varyingly approved of, restricted adherence to risk reduction policy). The role of communication, leadership, and training of prison authorities must then be reaffirmed in order to carry on rallying teams around updated public views, as well as encouraging the right practices in prison is still crucial.

³⁹ That memorandum invited penal and health departments involved in prisons to investigate medical care requirements within the structure, and to define an arrangement of services likely to meet those needs in an efficient and coordinated way. That organizational scheme should clearly identify the part of each service involved in order to match up 5 purposes: systematically detect all abuse and/or addiction conditions by means of a diagnosis tool ("mini-grade grid"); suggest an adapted medical care; develop prevention particularly for risks connected with the use of substances; favour reduced sentencing; prepare the release of prisoners showing an abuse or an addiction.

10. Drug markets

Drug markets: general context

The TREND information system focuses on 2 areas. The urban scene is defined as the places in a town where active drug users may be seen (squats, in the street etc.). The party scene means party events, especially those from the techno culture: clubs, 'teknivals', 'free parties' and private parties.

Availability and supply: information on changes in minor trafficking (on the urban and party scenes) and accessibility and availability of products is gathered thanks to the TREND observation sites (Bello *et al.*, 2004).

- Cannabis is the most easily-available and accessible illicit product in France.
- Heroin is a product which is not readily available and not very visible. This situation has become more marked with the disappearance of the open drug scene and the fact that small-scale traffickers have moved into selling cocaine, which is more profitable.
- Cocaine in its base form is available both in the techno party scene and the urban scene; crack is mainly available in Guyana, in the Antilles and in inner urban Paris.
- Since the beginning of 2000 HDB (Subutex®) has become more available on the parallel market.
- In 2003 upsurge in the purchases of hallucinogenic mushrooms on the Internet, as well as self-growing at home.

Within the urban scene, trafficking since 2002 has tended to move to less visible premises and areas.

In the techno party scene, new regulations governing the organisation of events which were introduced at the beginning of 2002 have made unauthorised free party events rarer and there are more commercial techno parties. This has contributed to a certain movement of trafficking towards the urban environment: clubs and discos, private premises (private parties) and across the borders (Spain, Belgium).

Seizures: France is a transit country for substances intended for the Netherlands, Belgium, the United Kingdom, Italy and beyond and it is therefore difficult in France to separate the quantities of drugs intended for the domestic market from those which are just passing through. Trafficking in France therefore needs to be tackled according to the products since the country where they were procured and the country which is their destination vary depending on the substance in question.

Seizures recorded by the authorities (police, customs, gendarmes) in France are only a partial indicator of the illicit drugs available, because they are directly linked to the activity of the services concerned and because chance plays a significant role in the annual variations in the figures. Changes must therefore be studied over long periods.

The number and quantities seized on French territory are taken from the file on police questioning for the use of narcotics (FNAILS) managed by OCRTIS. The trends observed for each product are as follows:

- since the end of the 1980's and until now, there has been a considerable increase in the number of seizures and quantities seized of cocaine and crack.
- after an increase in the quantities of heroin seized in the 1980's and up to 1994, the trend which was then dropping off seems to reverse from 2002 onwards.
- since the beginning of the 1990's, the number of seizures and quantities seized of ecstasy have increased considerably although the increase in seizures of amphetamines was more moderate.
- the quantities seized and number of seizures of LSD dropped over the period 1990-2002 after peaking in 1992 and 1993. Seizures operated in 2003 and 2004 lead us to expect a comeback to the levels reached by late 90's-early 2000.

For the quantities seized and the number of seizures carried out over the past four years, see [Standard Table no. 13].

Price, purity: information on the prices and purity of psychoactive substances has been available in France since 2000, from the OFDT monitoring systems, TREND or SINTES (Bello *et al.*, 2004).

[Standard Table no.14] gives information on the purity of products over the last three years. [Standard Tables nos. 15 and 16] give the composition of products and the prices of the principal illicit products.

Marijuana is sold since 2002 at less than € 5 per gramme, and two thirds of samples analysed contained less than 5% tetrahydrocannabinol (THC). Cannabis resin, around € 6 per gramme on the market, contained mainly between 5 and 10% THC.

The average price for brown heroin in mainland France seems to have been falling since 2001 but there are considerable local discrepancies. The purity rate is mainly between 0 and 20%. The average price of an 8 mg Subutex® (HDB) table on the black market has been € 3 since 2002 although it was € 6 in 2000.

The prices of cocaine hydrochloride and free-base (crack) vary depending on the sites and social scenes where they are observed. In mainland France, the average price of a gramme of cocaine hydrochloride is € 63 and this seems to have been stable for 4 years. The purity rate of the cocaine seized is most often between 60 and 100%. The most-often used products for cutting are lidocaine, phenacetine and procaine.

Rounded prices remain the rule for ecstasy tablets with three-fifths of the tablets sold at € 10 each. Batch purchasing seems to be becoming more common. The tablet price then easily falls below € 5 or € 3. In 2003, of the tablets collected by SINTES, 89% contained MDMA and 93% contained at least one metamphetamine. The average was 54 mg of MDMA per tablet (compared to 56 mg in 2002, 63 mg in 2001 and 74 mg in 2000). Almost 4% of the tablets were high-dose (>100 mg). Dosage in powders and capsules containing MDMA was on average double that of tablets (51% MDMA in powders (33 doses); 53% in capsules (34 doses) and 24% in tablets).

10.1 Availability and procurement

The following detailed information describe observations made by The TREND system throughout 2004 (Bello *et al.*, 2005c).

Cannabis

Herb and resin are both major and easily available cannabis forms.

In French overseas départements (French Guiana, Martinique), the most common form is herb.

Sixty percent of users purchase from a trafficker, 24% grow cannabis at home, and 19% supply themselves in a foreign country, while purchasing on the Net is remaining insignificant (Table 31). Home growing ensures users of the quality of their substances, hence the attraction of such a supply mode.

Table 31: Cannabis supply modes among 1,633 cannabis frequent smokers (ratios on lines), 2004

	Never	Sometimes	Often/Always
Purchase from friends	22.1 %	27.7 %	50.2 %
Gifts	34.8 %	38.6 %	26.5 %
Purchase from a dealer	40.6 %	25.7 %	33.7 %
Self growing at home	76.0 %	13.0 %	11.0 %
Purchase from abroad	81.0 %	15.3 %	3.7 %
Purchase on the Net	98.1 %	1.6 %	0.3 %

Source: "Survey on cannabis frequent users", TREND / OFDT.

Heroin

The availability of heroin in its brown appearance (labelled as “brown sugar”) has been increasing in Lyons, Lille, Metz, Rennes, Paris, and Toulouse. Heroin in its white form occurs significantly less often.

Cocaine

Unlike crack, selling cocaine is a rather inconspicuous phenomenon. Group purchase and use and trafficking are the most common supply modes. In some French cities cannabis trade “infrastructures” have played some role in promoting cocaine: through dealers’ diversifying offer, cannabis dealers changing for cocaine trade which proves more profitable yet involving the same risks.

In France crack supply can only be operated in three locations: Paris, Guiana, and Martinique. In those places crack is mostly available openly. Dealers generally sell that substance in prefabricated packaged form (“rock”, “chunks”).

Ecstasy

Extremely available and affordable in the techno recreational area, ecstasy has been more and more occurring in the urban area, where it would become a substance in its own right, as it is more and more injected by users having no connection whatsoever with the recreational area.

Observers also report an increase of methamphetamines occurrence in clubs and discos.

Hallucinogenic mushrooms

Refer to Subsection 4.3 on [Users of hallucinogenic plants](#).

10.2 Seizures

More than 85,000 seizures have been operated by the law enforcement authorities in 2004; such a figure has been increasing steadily from 1998 onwards, as well as the amounts seized (Office central pour la répression du trafic illicite des stupéfiants (OCRTIS), 2005).

In 2004 seizures of cannabis, heroin, cocaine, crack and LSD are on the rise when compared with 2003 figures. Seizures of amphetamines, ecstasy, and methamphetamines are decreasing ([Table 32](#)).

Cannabis seizures register a dramatic increase as far as resin is concerned (78 tons in 2003, more than 103 tons in 2004), whereas seizures of plants, oil, and seeds are dropping off. There are three main ways for bringing cannabis resin into France: direct purchases in Morocco, indirect ones operated in Portugal, Belgium, and the Netherlands, and to a lesser degree those carried out in Algeria. Thirty percent of the resin confiscated was intended for French market, the rest being for other European countries (the Netherlands, Great-Britain mostly).

In 2004 27% of the cocaine seizures on French territory has been performed in both Parisian airports (Orly and Roissy), and nearly 430 smugglers have been taken in for questionings there. The cocaine confiscated was essentially intended for France, then Italy and the Netherlands, and lastly Spain and Great-Britain.

Crack trafficking is mostly confined in French overseas départements (DOMs): Guiana, Martinique, and Guadeloupe, which are near cocaine supply sources and where there is a steady demand for that substance. The seizures performed on French territory were nearly all intended to national users.

The quantities of heroin seized in 2004 have been the highest ones throughout last five years (557 kg). The French market supply is operated by three countries: the Netherlands, Pakistan, and Belgium. The target country is unknown in 20% of confiscations, but in 30% of

cases heroin was intended for France, in 16% of them for Spain, and in 10% of them for Nigeria and Portugal.

As in previous years, there is a significant share of ecstasy for two countries: the Netherlands and Belgium; that accounts for seizures being mostly performed in French Northern départements. As far as target countries are concerned, Great-Britain ranks first (33% of seizures), followed by Spain (22%), and France (20%).

Table 32: Number of seizures and quantities seized among major illicit drugs in France, 2001-2004

	2001		2002		2003		2004	
	Nb ⁽¹⁾	Qties ⁽²⁾						
Cannabis (kg) ⁽³⁾		62,172		57,113		82,512	75,770	107,748
<i>resin</i>		58,195		50,836		78,347	63,701	103,705
<i>herb</i>		3,922		6,146		3,994	10,205	3,932
<i>plants</i>		41		96		84	1,492	81
<i>oil</i>		3		5		49	26	3
<i>seeds</i>		11		30		38	346	26
Heroin (kg)	2,650	351	2,633	476	2,560	545	2,828	558
Cocaine (kg)	1,650	2,096	2,048	3,651	2,636	4,172	3,175	4,484
Crack (kg)		6		7		12	761	18
Amphetamines (kg)	111	57	149	151	181	274	252	76
Methamphetamines (kg)		0		16		4	0	0
Ecstasy (doses)	1,589	1,503,773	1,782	2,156,937	1,864	2,211,727	2,135	1,893,226
LSD (doses)		6,718		4,262		10,383	101	19,374
		Nb ⁽¹⁾		Nb ⁽¹⁾		Nb ⁽¹⁾		Nb ⁽¹⁾
Whole substances		53,534		65,907		76,124		85,810
Base 100 Evolution in 1998		112.4		138.3		159.8		180.1

(1) Number of seizures operated throughout the year. (2) Quantities seized throughout the year. (3) Between 2001 and 2003, among the whole quantities seized only resin and herb have been accounted for.

Source: FNAIS, OCRTIS.

10.3 Price, purity

The elements detailed below relates to year 2004 (Bello *et al.*, 2005c).

Cannabis

Price

When it comes to purchases below 50 grams, the medium price for one gram of cannabis resin varies between € 3 and € 4, according to locations surveyed. In Martinique the price ranks fairly higher (€ 6.8) than in Metropolitan France. Depending on the quality purchased, the medium price is decreasing: namely € 2.4/gram for a purchase between 50 and 500 grams.

For purchases below 50 grams, the medium price for one gram of cannabis herb varies from € 4.2 to € 5.7 according to locations observed. In Guiana and Martinique prices are significantly lower (respectively € 0.7 and € 1). As with resin, the price varies along with quantities bought: € 5 for a purchase between 1 and 9 grams; € 4.5 between 10 and 19 grams; € 1.8 between 20 and 49 grams; € 1 between 50 and 500 grams.

Purity

Throughout year 2004, cannabis samples have been collected among users, in order to evaluate contents and characteristics. Nearly 250 samples have been gathered in 4 French locations (Bordeaux, Dijon, Lille, and Martinique).

THC rates dramatically vary in cannabis resin or herb: from 1.1 to 26.1% (ratio from 1 to 24) for resin, and from 0.3 to 23.8% (ratio from 1 to 79) for herb. THC available per cannabis sample proves therefore highly random.

As for resin, a majority of samples (86%) rank between 5 and 15%, with average concentrations less strong in Morocco samples than in Dutch ones. Resin labels vary according to locations and years, so that it is impossible to know whether a specific name matches a specific quality.

When it comes to herb, most samples (63%) rank below 10% of THC rate. As in the case of resin, cannabis herb coming from the Netherlands is more concentrated than the one from France, West Indies or home growing (Bello *et al.*, 2005a).

Table 33: Distribution of cannabis samples collected in France, according to their alleged form and origin, 2004

Alleged origin	Resin			Herb		
	Samples collected	Distribution	THC Rate	Samples collected	Distribution	THC Rate
Unknown	20	21 %	9.1 %	5	3 %	11.1 %
Known	76	79 %	11.2 %	140	97 %	8.8 %
Morocco	55	72 %	1.05 %	0	0 %	-
Netherlands	9	12 %	13.3 %	36	26 %	13.5 %
Metropolitan France	4	5 %	9.0 %	55	39 %	7.2 %
West Indies	0	0 %	-	45	32 %	7.1 %
Others	8	11 %	11.9 %	4	3 %	5.6 %

Source: TREND/OFDT Data and exploitation.

Other substances

Heroin

In 2004 the medium price of one gram of brown heroin would be of € 35 in Metropolitan France, namely € 5 less than the previous year. Price disparity is typical of white heroin (€ 40/gram in Metz, € 100 in Paris).

Cocaine

In 2004 the medium price of one gram of cocaine is € 60, that is to say the lowest price ever recorded for these last four years; as that price is rather random, it would be difficult to claim any decrease tendency.

Ecstasy

The 707 pills collected in 2004 among users contain MDMA (86% of them), amphetamine (7%), and at least one amphetaminic substance (94%). In 2004 the average amounts to 61 mg of MDMA per pill (vs. 54 mg in 2003, 56 mg in 2002, 63 mg in 2001, and 74 mg in 2000); that goes with an average concentration of 27%. About 5% of pills collected containing MDMA are dosed over 100 mg of MDMA (high dose), that is a slight increase when compared with the four previous years (4% in 2003, 3% in 2002, 2.5% in 2001).

Powders containing MDMA are more concentrated in active principle than pills, with an average 40 % of MDMA (45 dosages available); as well as capsules (50% on average, 28 dosages available).

The medium price of one pill sold per item has been decreasing from year 2003 (8.2 €). "Round" figures are still the rule since 43% of ecstasy pills are sold € 10 (vs. three-fifth in 2002). But the share of pills sold € 5 has been constantly increasing: 27% in 2004 vs. 18.4% in 2003, and 7.5% in 2002. When purchased in packs, the price of one pill just decreases below € 5 or € 3. The average price also varies according to locations: it is higher in discos or in bars than in the street or in a tecknival.

PART B : SELECTED ISSUES

11. Gender Difference

Do the uses echo significant differences in accordance with gender? Those observed in the levels of use and the drug use consequences request to regard gender as a vital issue for understanding such practices. This article not only aims at taking stock of the most recent epidemiological data, as far as drug uses and health and social consequences are concerned, but also at describing the main characteristics of male and female perceptions relating to psychoactive substances, as well as the relevant public policies.

Situation

Data issuing from surveys on alcohol, tobacco, medicines, and illicit drugs uses among adult population

General population surveys enable illustrating and quantifying the levels of use of different substances. Their results show that using licit or illicit psychoactive substances involves more males than females (Table 34 and Table 35), except for the use of psychotropic medicines that affects mostly females (Table 34).

Table 34: Regular uses of main psychoactive substances in France according to gender and age, 2002

	Alcohol 3 days of use and more per week	Tobacco Daily use	Tranquillizers or hypnotics* Weekly use	Cannabis* 10 uses and more during a month
18-75 Females	19.7%	25.6%	12.0%	0.6%
18-25	7.9%	37.1%	2.9%	3.4%
26-34	9.9%	38.5%	5.0%	0,5%
35-44	18.1%	31.0%	9.4%	0.2%
45-54	19.6%	21.2%	14.5%	0.0%
55-75	33.7%	9.7%	21.5%	0.0%
18-75 Males	42.8%	31.9%	6.1%	2.3%
18-25	23.5%	52.1%	1.6%	9.1%
26-34	25.1%	35.3%	2.9%	3.2%
35-44	37.2%	34.0%	5.1%	1.4%
45-54	51.0%	32.9%	6.5%	0.2%
55-75	61.6%	18.8%	11.3%	0.1%

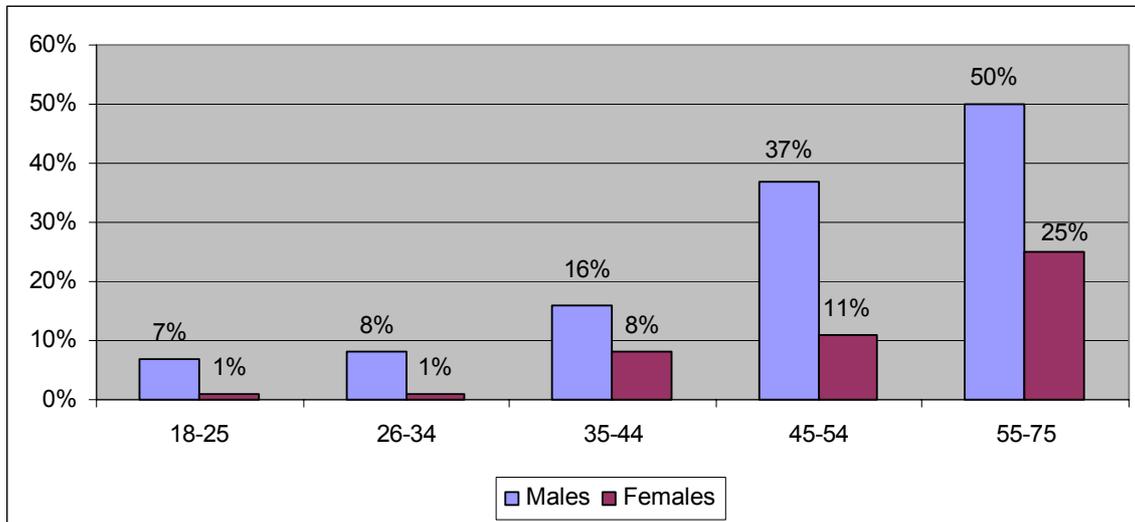
Sources: EROPP 2002, OFDT, except for *: Baromètre Santé 2000, INPES, run by OFDT.

Alcohol

In a context when alcohol regular use per capita has been dramatically decreasing in France since the late fifties (though this country still remains one of the main European users), males prove significantly heavier users than females. In 2002 nearly four-fifth (78%) of them drank at least once during the week prior to the survey, vs. less than six females out of ten (57%), and males are twice as many to drink on a regular basis (at least 3 days a week): 43% vs. 20% (Beck *et al.*, 2003). The gap is principally important among younger generations (Graph 6). The more significant the frequency of use observed, the more considerable the disparity

between males and females: it nearly reaches a ratio of 1 to 3 for daily use (28% vs. 11%, [Graph 6](#)).

Graph 6: Daily use of alcohol during last seven days, according to gender and age, 2002



Source: EROPP 2002, OFDT.

The gap between genders does not only relate to alcohol frequency of use but also to quantities drunk. On average the males respondents, who have drunk on the day prior to the survey, therefore acknowledge 2.9 glasses of alcohol vs. 1.7 for women. On the whole these differences in quantities convey a more frequent disregard of use recommendations as suggested by WHO (a maximum of 3 standard glasses for males, 2 for females). If 12% of the 18-75 year-olds admit having drunk on the previous day an amount of glasses of alcohol higher than that criterion, there are three times as many males as females in that case, despite a higher threshold (18% vs. 6%). The frequency of such uses increases together with age: it almost affects one third of males aged over 60 (Guilbert and Perrin-Escalon, 2004).

Lastly the gender difference can be observed in the frequency of alcohol intoxications. In 2000 14% of grown-ups declare having experienced one drunkenness at least during last twelve months. The yearly alcohol intoxication proves three times as more frequent among males (22 %) as among females (7 %), and significantly differs according to age, with a peak located between 18 and 25 years of age (51% of males and 22% of females). For those who admit having been drunk during the year, the average figure of drunkenness occurrences amounts to 4.6 (5 for males, 3 for females); it reaches 6 among the 18-25 year-olds (7 for males, 3 for females).

As far as health is concerned, the male chronic and more significant alcoholization therefore increases their risks to experience a problematic use. That can be objectivized thanks to the DETA Test that screens individuals having problems with alcohol⁴⁰, using general population surveys. Almost 9% of adults can be considered experiencing or having experienced a problematic use of alcohol (Legleye *et al.*, 2001). This kind of use with a risk of alcohol addiction, which generally increases along with age to reach a high point among the 45-55 year-olds (13%), proves more frequent among males than females (15% vs. 4% among

⁴⁰ In the DETA Test ((Ewing, 1984)), individuals are considered “risky” alcohol users if they answer yes to two questions at least among those following: Have you ever felt the need to decrease your alcohol drinks use? Have people around you ever made remarks upon your use? Have you ever felt you were drinking too much? Have you ever needed alcohol from the morning onwards to feel fit?

the 18-75 year-olds). The MGEN mutualists health survey carried out in 2001 among 6,650 members of that health insurance company, aged from 20 to 60 (Kovess *et al.*, 2001), shows results fairly close to those of the 2000 Baromètre Santé: among the mutualists, 14% have already felt the need to cut down their use (12% for males and 5% for females). Males are consequently more concerned than females by these problematic situations with alcohol.

The occupation proves an important factor bringing together male and female use behaviours. For example, among working individuals having a job, when the age effect is controlled, the odds ratios concerning males comparatively to females⁴¹ for an alcohol daily use, are around 7 among workmen, 4 among employees and intermediary occupations, yet 2 among executives and professionals or higher intellectual occupations. When it comes to drunkenness, the odds ratios concerning males comparatively to females are respectively close to 5 or 6 for workers, employees and intermediary occupations vs. less than 4 for executives, professionals and higher intellectual occupations. In other words, female alcohol use behaviours come closer to those relating to males insofar as you climb up the social scale (Beck and Legleye, 2005). Such a result proves particularly true as far as executives are concerned when compared with other categories. Briefly speaking, because females from higher social levels more often acknowledge drinking on a daily basis or having been drunk during the previous year than others, whereas the opposite can be observed among males belonging to the same categories.

Tobacco

Tobacco represents the substance for which the gender differences are less prominent, the female level of use having gradually come closer to the one concerning males during last decades. Although male tobacco addiction is slightly decreasing, contrary to the one relating to females, males remain smokers more often than females. Nearly one fourth of the latter declare smoking on a daily basis vs. a little less than a third of males. Behaviours hardly vary at middle ages (26-44 year-old) but the disparity proves higher among younger and older generations. The decrease in the level of use with age can be observed among both genders, yet more quickly among females: the male/female gap proves more significant beyond 45 years of age.

The important male/female disparity at 18-25 years of age can also be observed in other recent surveys (Oddoux *et al.*, 2001). It should however decrease eventually given the nearly similarity currently observed between male and female teenagers (Beck *et al.*, 2004b). Although male tobacco addiction has been dropping off since the seventies, in 2002 males still remain tobacco smokers more often than females (38 % vs. 31 %, [Graph 7](#)). As for females, the tendency appears comparatively steady in this period, even though infrequent evolutions and the small size of the samples used in some of these surveys give the curve a rather erratic aspect.

Psychotropic medicines

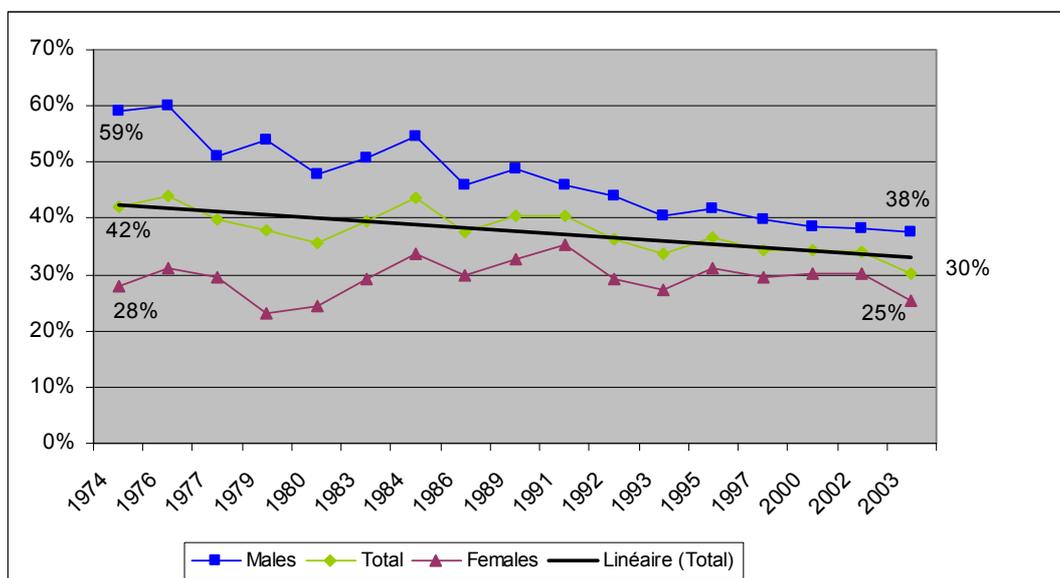
Among the 18-75 year-olds, there are twice as many females as males resorting to psychotropic medicines: 25% of them have had one intake at least during the year vs. 14% among males (Beck *et al.*, 2002). In three cases out of four those medicines are prescribed. Detailing each pharmaceutical category shows that 6% of males and 12% of females admit having used antidepressants during the year, such figures being respectively 12% and 20%

⁴¹ The odds ratio is a measure that makes possible to evaluate the probability for a population to have an A characteristic when having or not the B characteristic. Higher than 1, it shows that the population having B is more apt to have A than the population not having B; Lower than 1, it shows on the contrary that the odds are lower. Applied to male gender, it can be read as the odds presented by males comparatively to those presented by females.

for the group including tranquillizers (anxiolytics) and sleeping pills (hypnotics). Following what can be observed for alcohol, the weekly use of psychotropic medicines increases in conjunction with age for both genders, yet more acutely among women.

Such a female abuse can be brought closer to an anxiety more often acknowledged. When questioned within the framework of health surveys, there are actually more females than males to declare themselves anxious or stress-ridden in their everyday life, and they also more frequently admit having sleeping disorders (Aliaga, 2002). The pressure of sexually-differentiated descriptions must as well be emphasized in order to explain male and female disparity: a psychological disorder is often more commonly admitted among girls than among boys (Le Moigne, 1999; Lovell and Fuhrer, 1996). As far as girls are concerned, doctors are generally apt to diagnose a psychological cause for some physical troubles, as well as girls regard themselves more frequently as patients, when boys would naturally deny a psychological pain or cope with it differently, without psychological support whatsoever, often resorting to other psychoactive substances.

Graph 7: Current smokers ratios among 18-75 year-olds, 1974-2003



NB: As the methods set up in these surveys sometimes vary, with particularly some small size samples for surveys carried out in the nineties, less importance must be lent to the level of uses appearing on that curve than to the long-term tendency described by the linear regression line.

Sources: CFES surveys from 1974 to 2000; EROPP 2002, OFDT, INPES/IPSOS 2003.

Cannabis and other illicit substances

Apart from amphetamines, for which gender differences do not appear significant, when it comes to illicit drugs, there are between twice and three times as many males as females having already used them during their lifetimes (Table 35, Graph 8).

Such a disparity can be easily observed for cannabis, whose levels of use are significantly higher than those of other illicit substances. Cannabis is much more used among males: nearly 10% of young men of 18-25 are using it on a regular basis (ten intakes at least each month) vs. 3.5% of young females within the same age bracket.

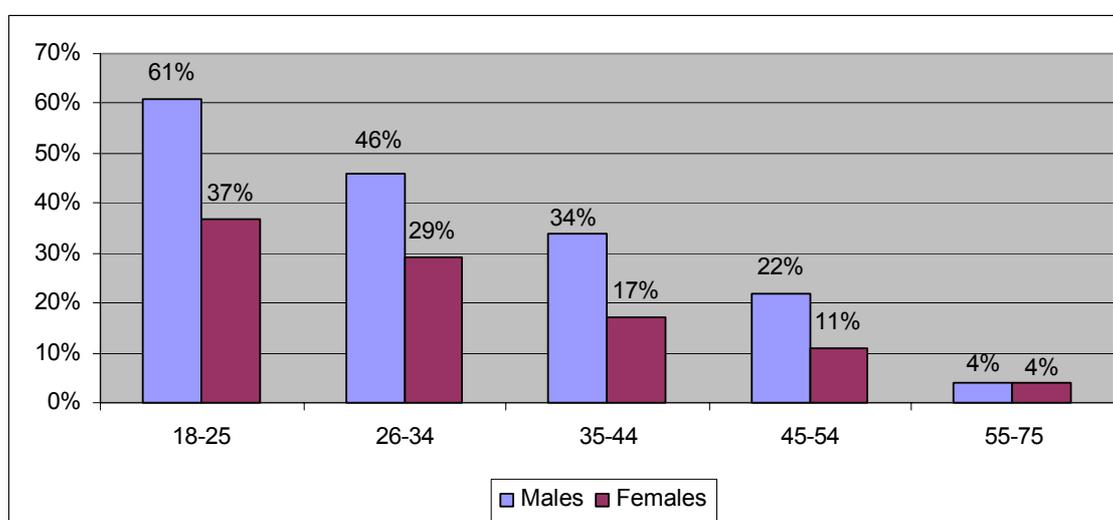
That difference can be measured whatever the age bracket or the level of use (yet beyond 55 years of age, the uses are uncommon enough for the gender disparities to be no longer significant). Therefore the yearly use concerns 9% of males vs. 6% of females.

Table 35: Experimentation of main other drugs according to gender among 18-75 year-olds, 2002

	Males	Females	Total
Glues and solvents	3.6%	1.7%	2.7%
Cocaine	3.3%	0.8%	2.0%
LSD	2.1%	0.2%	1.1%
Amphetamines	1.7%	1.2%	1.4%
Ecstasy	1.4%	0.2%	0.8%
Hallucinogenic mushrooms	1.4%	0.9%	1.1%
Heroin	1.4%	0.2%	0.7%

Source: EROPP 2002, OFDT.

Graph 8: Cannabis use during lifetime according to gender and age, 2002



Source: EROPP 2002, OFDT.

Finally, it can be said that the French gender-related profile appears comparatively similar to the one of all countries belonging to the European Union.

Data relating to treatment, morbidity, mortality and penal consequences

Data concerning treatment subsequent to alcohol use show a male/female disparity even more significant than in data relating to use. In 2002 the new patients attending CCAA's (Outpatient Alcoholism Treatment Centres) are mostly males (77 %) (Palle and Martin, 2004). In terms of mortality, pathologies pertaining to chronic ethylic impregnation are originally about four times as many among males as among females (Table 36). Nevertheless females prove more "vulnerable" to alcohol: the risk of cirrhosis becomes significant from a daily use of 3 glasses a day for females, and 5 glasses a day for males, as well as the increase of death risk appears after 2 glasses for females (vs. 3 among males) (OFDT, 2005a).

Females were as many as males to consult for a tobacco use between 2001 and 2003 (SPIM (Faculté de Médecine Broussais/Hôtel-Dieu), 2004), which confirms some similarity among genders as far as tobacco-addiction is concerned, although on average females consulting are younger (40 years old vs. 44 years old). In 2000 the French yearly amount of tobacco-related deaths has been estimated around 60,000 (Peto *et al.*, 2004). Such mortality essentially concerns males (90%), even if the method used for producing these figures may underestimate female mortality (Le Bot, 2003). In term of trends, the share of deceases caused by tobacco-addiction has been decreasing since the mid-nineties, whereas it has

registered a fairly rise since the early eighties among females, from 0 to 6% in 20 years (Peto *et al.*, 2004) (Graph 9).

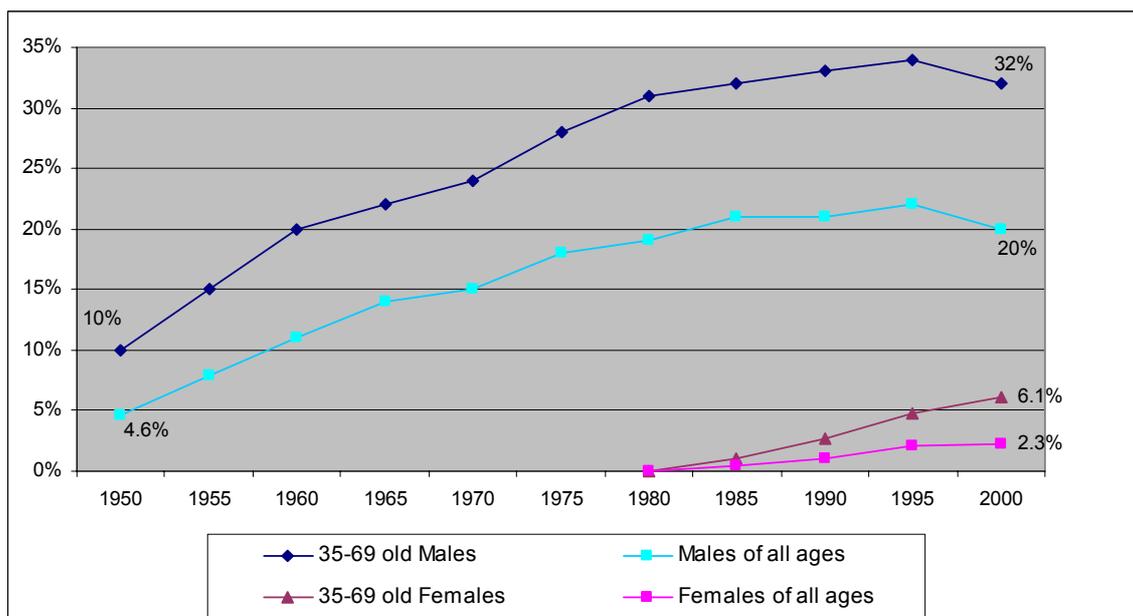
The male/female distribution among drug-related deaths (overdoses) reported to the police or the gendarmerie has remained comparatively steady in the nineties, the share of female deaths nearing 17%. In 1999 and 2001, it decreased to reach 11% in 2001. During the last two years (2002 and 2003) there are more deaths occurring among females (respectively 20.6% and 33.7%). Given the substances involved in these deaths, those containing no opiates are more common among females.

Table 36: Deaths directly relating to recurring ethylic impregnation in 2000

	Males	Females	Both
Cirrhosis	6, 067	2, 536	8, 603
Aerodigestive tract	9, 261	1, 601	10, 862
Cancers			
Alcoholic psychosis	2, 436	637	3, 073
Total	17, 764	4, 774	22, 538

Source: CépiDC, INSERM (National Institute for Health and Medical Research).

Graph 9: Ratio of deaths related to tobacco compared to the whole deaths, 1950-2000



Source: Data from CépiDC, run by CTSU / Oxford University.

The image of the population of illicit drug users supplied by the care system is similar to the one observed during general population declarative surveys. It mostly concerns males, as 80% of patients consulting CSST's (Specialized Centres for Drug Addicts) are men (Palle and Bernard, 2004) and registers the same differences according to substances: females experience disorders relating to cannabis and cocaine use less often than males, and more frequently register troubles caused by the use of psychotropic medicines. As far as substitution treatment is concerned, the ratio of individuals on methadone is more important among females, males being more frequently on HDB (high-dose buprenorphine) (OPPIDUM, 2001). In low threshold structures which only receive active users, the population met also includes 80% of males (Bello *et al.*, 2004).

When it comes to the health consequences induced by injecting illicit drugs, HIV prevalence appears slightly higher among females (18.5% vs. 15% among males), whereas HCV prevalence is similar for both genders, concerning about two-thirds of users resorting to injection and seen in specialized centres (Palle *et al.*, 2003).

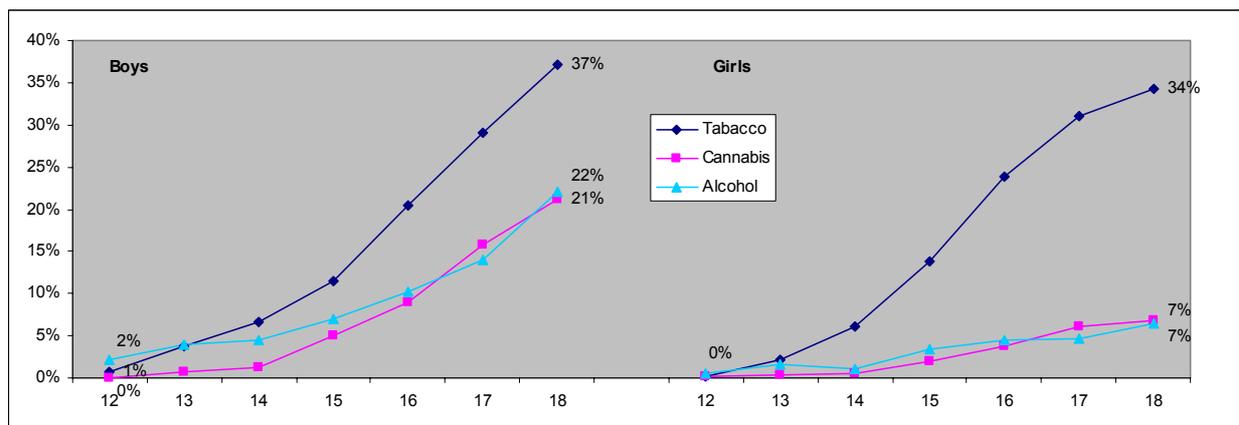
The female ratio appears even more insignificant in statistics from the repressive system: in 2003 barely 10% of individuals detained for simple use are females. About 80% of cases involves cannabis, such ratio being lower than the one relating to males (around 90%). Besides, the more you go through penal procedure, the more female ratio decreases.

In teenage population

The gender differences observed among grown-ups appear mostly since teenage: a use of medicines more common among females, similar tobacco-related behaviours, and the rest of uses more significantly pertaining to males.

Tobacco and alcohol regular uses appear to be comparatively occasional before 14 years-old, and the use of cannabis is outstanding before 15. Afterwards they increase along with age, yet the daily tobacco use notably surpasses the regular use of alcohol and cannabis. Therefore the ratio of daily tobacco smokers goes from 7% up to 43% between 14 and 18 among boys, and from 6% to 42% among girls. An increase with age can be observed for alcohol and cannabis use, especially among boys, and to a less extent among girls (Graph 10).

Graph 10: Regular uses* of tobacco, alcohol, and cannabis, according to age and gender, between 12 and 18 year-olds, 2003



*10 uses at least during last 30 days for alcohol and cannabis ; daily use for tobacco

Sources: 2003 ESPAD – INSERM – MJENR for 12-16 year olds; 2003 ESCAPAD (Survey on Health and Consumption on Call-Up and Preparation for Defence Day), OFDT for 17 and 18 year-olds.

The *sex ratio* (ratio of the shares of users among boys and girls) calculated for the use during last thirty days is very close to 1, as far as alcohol and especially tobacco are concerned, emphasizing the comparable distribution of the substance within both genders. On the other hand, it is significantly lower for psychotropic medicines, as the latter are mostly used by females, and notably higher for all illicit substances. It therefore amounts to 1.4 for cannabis (meaning there are 40% more males than females who have used cannabis during last thirty days), yet it is close to 2 for all other substances. Cannabis is then the illicit substance whose use is the most prevalent but also the most “gender-indiscriminating” (Table 37).

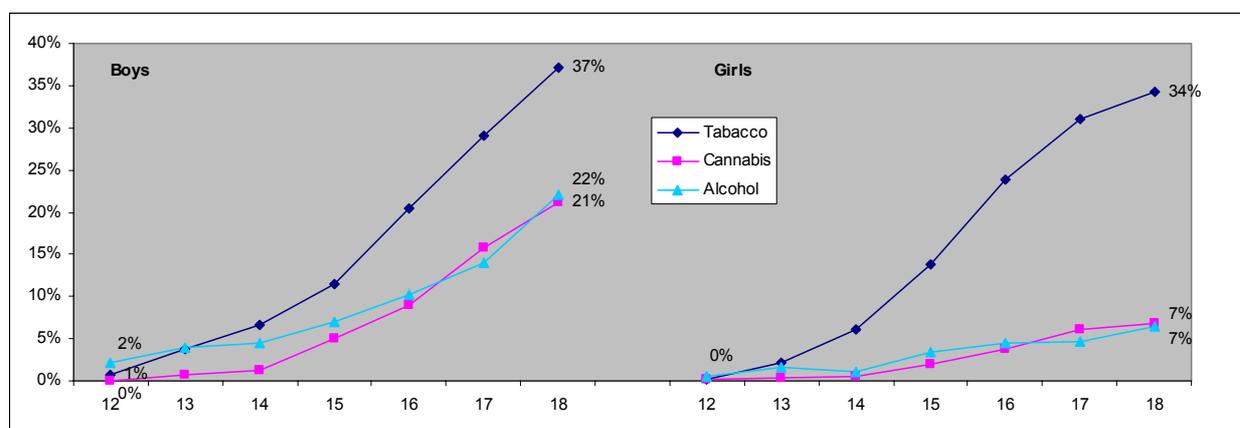
Table 37: Monthly use (last thirty days) of psychoactive substances among 17-18 year-olds (%), 2003

	Girls	Boys	Sex ratio
Alcohol	76%	84%	1.1
Tobacco	48%	47%	1.0
Cannabis	26%	38%	1.4
Medicines	18%	6%	0.3
Ecstasy	1.0%	2.2%	2.2
Mushrooms	0.6%	1.4%	2.3
Poppers	0.7%	1.3%	1.9
Amphetamines	0.6%	1.2%	2.0
Cocaine	0.6%	1.2%	2.0
Inhalants	0.5%	0.9%	1.8
LSD	0.3%	0.7%	2.3
Heroin	0.3%	0.5%	1.7
Crack	0.2%	0.4%	2.0

Source: ESCAPAD 2003, OFDT.

Among the three most distributed substances (alcohol, tobacco, and cannabis), alcohol registers the biggest disparities as far as regular use is concerned; the gender difference is stronger among teenagers (Graph 11). France shows a similar pattern to ones of all other European Union countries questioned in the 2003 ESPAD (European School Survey Project on Alcohol and Other Drugs) (Hibell *et al.*, 2004).

Graph 11: 2000-2003 Evolution of regular use for tobacco, alcohol, and cannabis, according to gender at 17 years of age



Source: ESCAPAD 2003, OFDT.

Opinions and perceptions of the substances and of public policies

Dissimilar when using psychoactive substances, males and females also disagree in their opinions upon these substances, their dangers, or the public policies pertaining to them. In 2002 when asked “Which are the main drugs you know, even just by name?”, only 3.7% of the 15-75 year-old respondents claim they do not know any. On average males notably state more substances than females (4.2% vs. 3.5%, $p < 0.001$), which tends to show a better knowledge or a greater interest in the subject.

However females seem more perceptive than males to the estimated dangerousness of the substances. When it comes to illicit substances, cannabis is characteristic. Therefore 50% of

females think that cannabis is dangerous as soon as you test it, vs. 43% of males, whereas 37% of the latter think it is only risky when you smoke it on a daily basis, vs. 29% of females. Likewise, there are more females who agree that smoking cannabis leads to using more dangerous substances (75% vs. 54%). Consequently, they less often than males regard cannabis prohibition as an attack on individual freedom (34% vs. 28%), as well as they less often support the possibility to allow cannabis use under certain conditions. For all these opinions, similar results can be observed in relation to ecstasy, cocaine, and heroine, even though the gender disparities are less significant.

On the other hand, opinions about the dangerousness of alcohol and tobacco are notably more divided, both males and females suggesting for example daily limits in numbers of glasses for alcohol or in numbers of cigarettes which are very close (respectively 3 glasses and 10 cigarettes a day). Public health campaigns have undoubtedly born fruit for these substances, but the greater distribution of the latter also play an important part.

While opinions upon substances appear dissimilar according to gender, such judgement must be moderated when other parameters are accounted for. First of all the substances considered: judgements issued by both genders are very near for the allegedly dangerous substances as heroine, and they match when individuals experiencing the same closeness to the substance are surveyed (whether they are users or have already used it, or know users around them). But on the whole, if females seem more apt to judge them more severely, it is because they are notably fewer than men to use them. Lastly, the social background also plays an important part, the social level of the individual from the reference household bringing closer the opinions of both genders, as well as the use.

The conclusion is similar as far as the opinions upon public policies are concerned.

Responses

Gender approaches in the systems addressing to children and teenagers

Prevention at school

On February 26th, 2003 the minister of state to school education gave a paper to the Cabinet concerning school context⁴². Preventing addictive behaviours appears as a main concern to be developed in close partnership with MILDT (Interministerial Mission for the fight against drugs and drug addiction).

Following that policy, a five-year prevention and education program covering the 2004-2008 period promulgated by the circular letter of December 11th, 2003, n°2003-210 (NOR: MENE0302706C) echoes the 2004-2008 Government Plan for the Fight Against Illicit Drugs, Tobacco, and Alcohol (MILDT, 2004), and works on the principle of a “school providing to each pupil and educational areas, with satisfying covering ratio and quality, a personalized preventive education against alcohol, tobacco, cannabis and synthetic drugs”.

At the present time, the gender problematics does not appear in the planning strategy for preventing addictive behaviours in the school environment. As it is expounded in the *Bulletin Officiel* of December 11th, 2003⁴³, such a step is only presented as “all the more vital as it

⁴² Paper given to the Cabinet by the minister of state to school education concerning youth health in the school context , February 26th, 2003. Sex education in primary and secondary schools. Circular Letter n°2003-027 of December 17th,2003, NOR:MENE0300322C RLR : 505-7, MEN DESCO B4.

⁴³ Pupils' health: a five-year prevention and education program, Circular Letter n° 2003-210 of December 1st, 2003, NOR: MENE0302706C, RLR: 505-7, MEN - DESCO B4

stands for a national policy for preventing and reducing risks —unwelcome early pregnancies, STD's (Sexually Transmitted Diseases), HIV/AIDS — and justified by protecting the youth against sexual violence or exploitation, pornography, as well as the fight against sexist or homophobic prejudices"⁴⁴.

A INSERM/OFDI Survey on assessing, within the school context, a primary prevention program relating to drug addiction suggested since 1999 the need to think about preventive actions pointing towards boys (Choquet *et al.*, 1999). Because of the inadequacy of the messages and the prevalence of females in the health environment, the authors would suggest some courses of action aiming at specific programs, male contributors, and a selection of prevention areas.

In 2004, the OFDI (French Monitoring Centre for Drugs and Drug Addiction) initiated a call for tenders for a survey upon the applicability and the usefulness of an intervention manual in the school environment on the addictive behaviours prevention (OFDI, 2004b). The final manual is to be issued by September 2005.

Prevention in recreational settings

Inside risk reduction community associations some programs are appearing, which aim at female users within the techno area. For instance, the flyer labelled "Girls, Substances, Sex and Risk Reduction" is based upon an "in-between peers" communication mode (Ruptures, 2004)⁴⁵. As in other risk reduction flyers, the following help line numbers are mentioned: *Drogues, Alcool, Tabac Info Service; Sida Info Service, Hépatites Info Service*, as well as the *Contraception, IVG, Sexualité* numbers.

Prevention in general population aiming at girls/boys groups

Interpreting the last Government Plan of Fight Against Drugs from a gender perspective enables us to extract the main lines of prevention policies and their searched for effects according to gender.

The tobacco campaigns due for the next three years aim at changing the tobacco risk perception, and to make social images evolve in addressing the groups whose use tends to increase, including these of boys and girls. The communication mode of these campaigns plays on various forces allegedly regarded as connected with the gender, as the pregnancy

⁴⁴ It is based upon the following texts:

- November 24th, 1998 Circular Letter n° 98-234, "Courses of Action For Health In Primary And Middle Schools", which would be subjected to alterations following the reports from the National Education General Inspectorates and the Social Services General Inspectorates, whose conclusions were to be issued by the end of 2003;

- July 1st, 1998 Circular Letter n° 98-108, "Risk Behaviours Prevention and Health And Citizenship Education Council";

- July 7th, 1998 Circular Letter n° 98-140, "Citizenship Education in the Primary and Secondary Schools";

- January 12th, 2001 Circular Letters n° 2001-012, "General Orientations for an Health Policy in Consideration of Pupils"; n° 2001-013, "Missions of National Education Doctors"; and n° 2001-014, "Missions of National Education Nursing Staff";

- Circular Letters n° 2002-024 of January 31st, 2002, and n° 2002-111 of April, 30th, 2002: "School Adaptation and Integration: useful resources for a successful schooling for all pupils";

- February 17th, 2003, "Sex education in primary, middle, and secondary schools".

⁴⁵ "If you have run a risk, think of double testing (pregnancy, STD's) and emergency treatment (HIV). When you go out with friends, care for each other. In all festive venues, watch your drinks to prevent anybody to pour some 'additive' in it. Think of drinking a lot to avoid dehydrating. When you meet some boy or girl, you aren't compelled to follow his/her gang of buddies! Use male or female condoms: prevention must be debated and shared. Consulting your gynaecologist is vital: once a year at least. The pill don't protect you from STD's but only from unwelcome pregnancies. Beware of forgetting when you're on some substances and/or substances causing nausea. Remain cautious when facing a substance whose effects are unknown (Seeing its effects upon others isn't enough). Rather experiment moderately and in good company. Don't share your own injection and sniff instruments, and have your own on."

risk, the contradiction between seducing and the effects on beauty, or between addiction and the quest for freedom (INPES, 2001). In terms of tobacco use decrease, the five-year plan aim at cutting down experimentation and delaying its age from 14 to 16 years-old.

Concerning alcohol, the purposes are:

- Decreasing prevalence of recurring drunk behaviours (more than three occurrences a year) among males, with a success level expected to be under 20% by the end of the five-year period;
- Decreasing the ratio of males presenting a problematic alcohol use;
- Making males aware of male overexposure to alcohol, and change the images connecting alcohol with manliness;
- Promoting a complete alcohol abstinence during pregnancy.

Gender approaches in preventing and reducing risks relating to drug use

Reducing risks in male and female injection practices

At present, there are no French coordinated indicators concerning injection reduction programs according to gender.

As far as injection-related risks are concerned, the “Point d’injection-Femmes” and “Point d’injection Hommes” flyers are largely distributed throughout the care and prevention networks, as well as on the Internet.

Reducing risks and STD’s⁴⁶

In the late nineties programs have been developed, whose open purposes were to cut down the risks of HIV and hepatitis infections, STD’s, and unwelcome pregnancies, with and among females. Such systems still in use in big cities (including Lyons, Marseilles, and Toulouse) involve, depending on the local network energy:

- French Family Planning Centres;
- Community health associations with prostitute individuals;
- Prevention and risks reduction associations in heterosexual multipartnership environment;
- Risks reduction associations operating with and among female drug addicts and/or living in the street;
- Health associations for migrating individuals;

There are no indicators on a national level (standard report model) to evaluate the extent of such programs.

Health facilities for male and female sex workers

Associations operating within the prostitution context mostly meet women. Males and transgender individuals working in the street principally offer sexual services to other males. The bus tours set up in the nineties in Paris (following the previous model of the AIDES Association bus) have been developed in other large cities outside the Paris area. There is no national assessment of the facilities offered (social and judicial counselling, popular education, training classes aiming at helping individuals to find a job, etc.) and of the prevention equipment (male and female condoms, gel, dental dams, sniff kits, injection kits, and more infrequently crack kits) (Cagliero and Lagrange, 2004; Laurindo da Silva and Evangelista, 2004).

⁴⁶ Sexually Transmitted Diseases.

Health facilities for pregnant women using drugs

Within the five-year plan framework, among target groups, or through health experts, pregnant women are being addressed direct messages aiming at a complete alcohol, tobacco⁴⁷, and other drug abstinence during pregnancy.

While there are specific structures for pregnant women, the ANAES (National Agency for Health Accreditation and Evaluation) and the SFA (French Society of Alcoholology) have emphasized the particular effort yet to be made within the alcohol and pregnancy problematics still denied by professionals, and the lack of public information (recommendations made in 2002). In 2004 preventing the foetal alcohol syndrome is one of the goals of the public health program planning law⁴⁸.

In 2003, the GECA Survey (Group of Studies on Pregnancy and Addictions) upon pregnant women on methadone or high-dose buprenorphine substitutes, and their babies' characteristics (Lejeune *et al.*, 2003) underlined the fact that defining a health risks reduction strategy for heroin addicts lead to an overall improvement of practices and medical observations among females on substitution treatment during their pregnancies, and their newborn children⁴⁹.

Main recommendations given as a conclusion to the survey:

- To favour the continuation of training classes with experts, by bringing together in common sessions all the various local contributors of perinatal centres, specialized care centres in drug addiction, alcoholologists, general practitioners, social services, to clear up all remaining reservations and lack of understanding among professionals;
- To favour the involvement in perinatal and gynaecological problems of cross-disciplinary addictology teams who care both for psychotropic misuses and poverty, which seem to be a more deciding factor than the substances intakes in perinatal complications;
- To develop the presently insufficient availability of mother-child reception centres (follow-up and rehabilitation care, accommodation structures with psychosocial funds, therapeutic apartments). In some cases, these centres could also prepare an agreed separation with mother and child keeping in touch;
- To solve disparities between regions as far as methadone centres supply are concerned.

Health facilities for drug users having young children

In alcoholology, there are post-cures receiving women with their children. As far as care for 0 to 6 years-old children is concerned, the CAMPS (Early Medicosocial Services Centres) present their missions as favouring the young child's integration into his family and social circle in close partnership with the family concerned.

⁴⁷ The goal being to cut down by half the number of female smokers during their pregnancies by 2008.

⁴⁸ August 9th, 2004 Law n°2004-806, NOR SANX0300055L: “-Art. L. 631-3. The initial and permanent training of all health and medico-social area professionals includes a specific teaching dedicated to the alcohol effects upon the foetus. The purposes of such a course are to favour prevention through information, as well as diagnosing and guiding the women concerned and the infected children to specialized medical and medicosocial services”.

⁴⁹ Among 259 women on substitution treatment, recruited in 35 perinatal care units throughout the whole French territory, between October 1998 and October 1999, results proved to be unexpectedly close to “normal”. (Lejeune *et al.*, 2003, p. 4)

The knowledge of some drug addiction care structures as “Les Capitelles” in Nîmes and “Horizons” in Paris are regarded as examples within the discussions and trainings offered by the ANIT (National Association of Drug Addiction Workers)⁵⁰.

- “Les Capelles”, a specialized care and accommodation centre for female drug addicts, includes 6 individual apartments distributed around Nîmes, and provides women and their children with “an environment whose purpose is to shore up the mother-child relationship, strengthen the break-up with substances, and prepare a reintegration which takes the mother-child relationship into account. [...] The female residents are granted a psychological (support, personalized guidance) and socioeducational follow-up (assessment of the social situation, development and set-up of a personal project, support throughout the mother or child integration process)”.
- The “Horizons” centre outlines more precisely its residents: young female drug addicts being pregnant, drug addict mothers with their children, couples with one drug addict member, drug addict fathers with a child, parent substitutes for children born from drug addict parents. In 2004 the UDC (Coordination Unit for Maternity and Risk Situations) and the ESSAD (Specialized Home Care Unit) have been gathered together into one whole structure: the DAPSA (Support Facility for Parenthood and Addiction Care). The UDC’s purpose is to favour movement and cooperation of professional contributors among pregnant women or drug addicts with children having to face grave difficulties. The ESSAD offers guidance and psychosocial follow-up for young mothers or couples with child, when these adults are not able to go through a care procedure in the operating appropriate structures.

There is no gender data pertaining to the evaluation on a national level (unsynchronised data collection) of specific care facilities for parents and their children (Duburcq and Sannino, 2003).

Prevention of drug-related morbidity and mortality

Following the European project to set up indicators for mental health monitoring⁵¹ (completed in 2002), France should create a system covering psychiatric morbidity, positive mental health, data regularly collected by the health structures and the mental health social factors. Such a system would contribute to mental health promotion and risk factors prevention programs, on the basis of socio-demographical, contextual, and geographical elements collected (Lovell, 2004).

According to Anne Lovell (2004), monitoring determining factors in suicide should take into account a series of economical, social, and psychometrical indicators. A significant example is the one concerning male grown-ups, underemployed or unemployed, alcoholic and depressed, maybe living in a geographical area affected by economic crisis. Some social groups show an “over-suicidality” as in the case of prisoners. Young alcoholic males suffering from personality disorders and depression seem to be more apt to commit suicide.

⁵⁰ In 2005, among seven training classes offered by the ANIT, the main issue of two of them is “female drug addicts”: “Drug addiction and parenthood. Drug-addict mother, women in question”, in January 2005; “Female drug addiction: women once more in question”, October 2005.

⁵¹ Within the framework of the “Psychiatry and Mental Health, 2005-2008” Plan presented by the Ministry of Solidarities, Health, and Family, mental health is considered from three points of view: “the positive mental health covering personal development; reactive psychological distress which includes trying situations and existential difficulties; and the psychiatric disorders which refers to a diagnostic classification leading to standards and targeted therapeutic actions, and corresponding to troubles of various duration, gravity and crippling quality.”

Deceases mostly concern males and suicide attempts mostly females (Badeyan and Parayre, 2001).

Gender approaches in treatment organization

Within the context of an important collective thinking upon the AIDS epidemiological assessment issued in 2003, the authors call attention to the way the epidemical situation has deeply and permanently branded homosexuality social experience and identity construction both for males and females, in France and Western societies (Broqua *et al.*, 2003).

As in several Western countries, the team insists upon the increase of risk-taking among male homosexuals and therefore upon new HIV⁵² infections. The writers describe the gathering of factors favouring that return of risk-taking: inadequate information and insufficient prevention among the younger, drugs and alcohol use, Internet meeting, multitherapy impact, and weariness (Janier *et al.*, 2003).

As far as prevention and treatment facilities are concerned, the VESPA Survey (ANRS, 2004) researchers nevertheless observe that public health programs giving easier access to injection kits (from 1987 onwards), then to substitution treatments (since the mid-nineties), have brought down virus transmission between drug users. As time goes by, that very early and massively infected group only forms a very slight share amid new diagnosed cases, both among males and females.

Gender approaches in social reintegration structures

While there is no national system of data collection for social reintegration programs, the experience of “Parenthèse de femmes” must however be accounted for. A female drug addicts workshop gathered around the “taking care of oneself” concept⁵³ (Ruptures, 2002), an action which is relevant of other unrecorded projects scattered around the French territory.

Such a program was set up following the deductions that other care structures in most French towns would share:

- “cramped premises, bathroom installations badly equipped for both genders; women attending the workshop had some trouble to find intimacy for washing themselves and body care. As those same women would often live in great difficulties, they were not better off in their living premises (squats, shelters, street...).
- The users’ wish to have some place for discussing strictly female issues, as sex (pregnancy, desire, violence, etc...), women’s right, beauty, etc... Yet also a need to talk about their own backgrounds, feelings, and relationships with the substances.
- The debate at stake for several years in Lyons and its area, on the issue of psychological vulnerability of females facing HIV” (Ruptures, 2002).

From those conclusions onwards, Ruptures (Care community association for risks and harm reduction with drug addict individuals), set up a program based upon workshops conducted by outside contributors: psychomotricity; sophrology; beauty care; hammam; updating one’s knowledge (genitalia, contraception, reducing sex-related risks); changing one’s image.

⁵² Although indicating that no epidemiological data has proved it so far.

⁵³ Financed by *Ensemble Contre le Sida*.

Within the framework of the 2004-2008 Government Plan, some courses of action are suggested in order to help social reintegration of the most vulnerable groups. For example, measures pertaining safety at work for most exposed jobs should be strengthened.

During last years, job accidents have decreased but risks remain higher in these groups, in which psychoactive substances are higher too: poorly qualified, temporarily working or recently hired young men. The list of jobs and job situations with accident risks, including road accidents at work and going to/from work, must be updated in order to identify the main areas to be accounted for, then operate some action upon working conditions and safety aiming at job accidents relating to the use of alcohol, cannabis and other substances.

Gender approaches in the penal procedure

A survey upon nurse staff and jailed male patients, their conditions, and prison care practices⁵⁴ (Bessin and Lechien, 2000) shows the relationships which can settle among prisoners and female nurses, as they may stand for an intimacy challenge gathering sex values and practices which prove significant in the gender-discriminating world of prison.

Through the depiction of care access, medical secrecy preservation, building confidence, coping with body confinement, and emotional pain, are revealed the possible uses of nurse performances by prisoners, as well as those of the denial that fits in the defiance strategy based upon valuing maleness, which is peculiar to the prison context. An “over-maleness” both males and females describe as *“a set of behaviours intended to make confinement bearable, and appealing to body control: body discipline and acquiring or maintaining a strictly physical authority, being clearly aware of harassment and hostility towards guards [...], denying the institutional offer upon which suspicion rhetoric lies heavy, and rejecting medical care especially”* (Bessin and Lechien, 2002).

About the future of released prisoners, a first survey, carried out in 2001, attempted to make up for the lack of assessing the released prisoners programs (Prudhomme *et al.*, 2003). Centred on male leavers, it could not answer the question of the UPS's (Care Units For released prisoners) efficiency in terms of impact on their mortality⁵⁵, yet it contributed to a better information on male released prisoners mortality. A significant over-mortality among ex-prisoners was observed during the first year following their release when compared with general population. Such an over-mortality, detected among leavers under 55 years of age, was notably high for overdoses.

The “Quartier Intermédiaire Sortantes-femmes” (QIS-femmes; Female Leavers Intermediate Ward) is a structure set up from 1997 onwards in three French penitentiaries (Fleury-Mérogis, Versailles, and Fresnes) to prepare the release of volunteer female prisoners with drugs or alcohol issues. That non-compulsory program is managed both by professionals, inside or outside the prison, providing information, guidance and training on various aspects of the prisoners' next release: health issues (reducing risks relating to drugs and sex; relationship with one's body), support networks (help to renew the links with one's family; putting the future leavers in touch with support associations for prostitute individuals), and the ability to live one's life day by day in the “after-prison” period (daily tasks at home, finances). During the first years of operation, the ratio of reincarcerated females after being released only amounted to 10% in the group of those having attended the program, vs. 40% to 50% for other female prisoners.

⁵⁴ Financed by the GIP (Group of Public Interest) Mission de recherche Droit et Justice (Law and Justice Research Mission)

⁵⁵ Because very few leavers went through the QIS (Leavers Intermediate Ward), whereas that prison was selected as pilot for UPS.

Facts for discussion

The EMCDDA recent surveys on male and female drug uses in Europe would point out the need to identify gender influences upon behaviours for a better understanding of their meanings, and developing the appropriate answers (EMCDDA, 2005; Montanari and Colin, 2004).

To avoid any fractional reading that would boil down to spotting a “female specificity” in drug uses, the historical and social part of sciences (among which the medical ones) in building female and male characters and legitimising social roles, as well as the male predominant role must absolutely be accounted for (Lowy and Gardey, 2000).

Therefore following the gender framework as an analysis category enables us to reaffirm to what extent *“the specificity that would differentiate female gender, the whole and full of an inevitably human gender, yet concealing that characteristic [then] seems to be a party to larger representations which fundamentally organize social issues and thought”* (Lowy and Gardey, 2000, p.13). Here we can spot what Joan W. Scott (Scott, 1986) would say about “qualities” which are granted to genders: they lie within the scope of thought system or concepts built at various periods, and having various contents, which concepts obviously depending upon prevailing power in the society surveyed.

Whereas Anglo-Saxons had long ago developed the “gender studies”, France appears to be significantly late in that field, even when compared with other European countries (Le Feuvre, 1995). From the seventies onwards researchers have observed that gender conceptualisation was based on *“a naturalist thought, and more precisely on a biologism whose characteristic is that it only applies to women”* (Guillaumin, 1978; Mathieu, 1973). It was not until the eighties that the significance of gender issues gradually stood out in social sciences researches on alcohol uses by females and males. But progress is very low sometimes: Berthelot et al. (1984) revealed the survival of stereotyped visions of a “female nature” which has not disappeared yet from the domain of alcoholology in France (Membrado and Clement, 2001).

Therefore the various alcoholization modes urge to relocate the different ways of drinking within larger frameworks exploring social practices, values and sociability, what varied anthropological studies with gender critical remarks attempted to show (Douglas, 1987; Nahoum-Grappe, 1991).

According to that present change, France is involved in the project labelled “Gender, Alcohol and Culture, an International Study” (GENACIS) (Bloomfield *et al.*, 2005). From data issued from most European countries, the GENACIS Survey has recently make possible to show that the more sex parity is respected within a country, the less alcoholization gender disparities prove significant. That is notably true in Scandinavian countries. Consequently there is a number of factors affecting the nature of gender differences from one country to the other, and no one stands for an ideal standard when it comes to alcoholization culture. The study mostly reveals that the alcohol use sex ratio seldom evolves along with age for the various pointers at stake (occasional or regular use, drunkenness...), except for heavy sporadic uses (*“binge drinking”*) for which young females’ practices comparatively match young males’ (Bloomfield *et al.*, 2005).

In France, similar results can be observed in recent surveys which cross-examine gender, sexualities (heterosexuality, homosexuality, and bisexuality for males and females), and health (violent behaviours, HIV, drug uses).

To outline them briefly, from the thought given to the National Survey on Violence Against Women, performed in 2000 (Jaspard *et al.*, 2003, enquête ENVEFF), and those carried out

within the realm of the (VESPA)⁵⁶, HIV-Survey on individuals infected, performed in 2003, and more largely within the HIV research field, we will draw attention to the following features:

- When it comes to females having homosexual intercourses or being attracted to females (Lhomond and Saurel-Cubizolles, 2003): they would rather locate within socially favoured categories, and mostly live in large cities. Rather single, they enjoy a more varied sex live, since an earlier age, with a greater number of partners, mostly men. They often smoke, acknowledge more frequent uses of alcohol and especially of other drugs. They more often suffer from physical or sexual attack, and their health conditions attest more frequent psychological ill-beings (notably more suicide attempts). Such results (coherent with Anglo-Saxon data) echo situations combining autonomy and social marginality.
- Generally speaking, such surveys confirm the close connection between brutalities suffered (whether they are sexual or not) and uses of alcohol yet not those of cannabis (Beck and Brossard, 2004, notamment). Nevertheless the ENVEFF group, as well as several researchers (Jaufret-Roustide, 2003) interested in the theory of risks synergy⁵⁷, advise against a somewhat frail exercise that could lead to “tackle stereotypes”. The ENVEFF group insists upon the need to strengthen scientific data production on the subject matter of gender, sexualities, the use of psychoactive substances, and to integrate indicators on the kinds of drug uses in watch and research facilities pertaining to sexual and preventive behaviours, in order to check theories about risks synergy.
- The first results of the VESPA Survey have been recently published (ANRS, 2004; Lert *et al.*, 2004). Males are the majority (over 7 out of 10 cases), many infections coming from a sexual transmission between men, or drug use through intravenous mode, which is mostly male. The levels of use of different psychoactive substances are high; they vary a lot in keeping with age, gender, and groups making up such population. The drug users are distinguished by low educational and professional status⁵⁸. The high level of medicines use⁵⁹ reveals a frequent psychological ill-being.
- The research groups underline the fact that the involvement in drug uses and its consequences on social life and health are closely connected both with social class, gender, and ethnic origins.

Concerning psychiatric morbidity, highly differentiated troubles and diagnosis can be observed, as far as gender is concerned, those also resulting from practices strongly attached to the traditional male-culture/female-nature dichotomy (Mathieu, 2000; Oudshoorn, 1994).

From a clinical viewpoint, therapeutic strategies may vary in relation with gender. In surveys pertaining to connections between drug uses and psychiatric troubles, there are too few

⁵⁶ The VESPA-ANRS Survey was carried out in Metropolitan France in 2003, among a sample of 2,932 individuals hospitalised for HIV infection.

⁵⁷ Situations in which risk taking increases are also those when substances use occurs on a more frequent and more intense basis.

⁵⁸ Only 38% in working life in 2003, a ratio having registered a 19 points drop-off since the diagnosis.

⁵⁹ During last thirty days, 21% of patients surveyed declare having taken anxiolytics, 14% hypnotics, 10% des antidepressants, and 2% des neuroleptics. Such occurrences are similar among both genders, as well as in the four medicine categories; they are more frequent among drug addicts, homosexuals, and bisexuals ((ANRS, 2004)).

utilizable elements for illicit drugs. The same cannot quite be said when it comes to tobacco, alcohol, or medicines.

Among factors accountable for the trouble to achieve a successful tobacco smoking cessation, for example, weight gain and the appearance of anxiety troubles play a more significant part among women. The average weight gain is one kilo higher among females, and anxiety or depression troubles are twice as more frequent among them (Lagrue, 2004).

Likewise, Lovell (2004) underscores that psychiatric morbidity is suggested in different troubles according to genders: depression occurs more often among females, whereas among males troubles connected with abuse and/or addiction to alcohol and drugs, as well as personality troubles are more frequent. However the connection between depression and alcohol must be moderated as numerous surveys call attention to the burden of financial situation in depression troubles. In France job situation (and the possible joblessness) seems to be the socio-economical factor mostly connected with depression, among males or females equally. Poverty measured by the fact they are granted the RMI (Integration Minimum Income) appears to relate to severe depression among males (Lovell, 2004).

Some epidemiological surveys show that despite a “somewhat” psychological vulnerability to alcohol, females suffer less often from nervous troubles of alcoholic origins than males. On the other hand females would be diagnosed as depressed twice as more often as males (Busfield, 1996; Plant, 1997). Therefore males and females would express their anxieties differently: significant use of alcohol among the first, depression and resorting to psychotropic medicines among the latter (Lovell, 2004; Tomes, 1990).

These last years, reports supplied by research teams and prevention-risks reduction contributors having integrated gender (and sexualities) issues in their research or action devices conclude identically upon the lack of funds to make the most of such approaches. In 2005 among the research (and research-action) financing programs, gender has not appeared yet in the MILDT call for tenders (contrary to other health fields as the HIV one).

May 2005

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12. European Drug Policies: Extended Beyond Illicit Drugs?

Official Endorsement by the National Drug Strategy

Since 1999, the sphere of activity of the MILDT (Interministerial Mission for the Fight Against Drugs and Drug Addiction) — an institution responsible for defining, setting up, and coordinating the French drug-related policy — has been extended to licit substances, such as alcohol, tobacco, psychoactive (hypnotics, neuroleptics, anxiolytics, and antidepressants) and doping substances. The 1999-2000-2001 Triennial Plan for the Fight Against Drugs and Addiction Prevention has indeed revealed a significant break in defining a strategy directed to a “global approach”, coherent with broadening the notion of “drugs” to licit substances (MILDT, 2000). The full approach has been based upon a medico-scientific consensus which consider addictive behaviours, their causes and consequences, regardless of their legal status.

Such an approach, although acknowledging the pharmacological and social specificity of each substance, gives precedence to use behaviours over substances. That bias brings about specific effects in the way public policies are organized. For example, prevention has been planned in discriminating several purposes:

- Delaying the encounter and experimentation with a psychoactive substance;
- Preventing the development from use to harmful use or addiction;
- Preventing harm done by certain kinds of uses, and addiction.

Likewise, the social and health system, basically directed to addiction reference, has been adapted in order to account for the notion of “harmful use” and the broadening to licit substances. At that period were laid the basis for organizing a general policy of care for abuses⁶⁰, which recommended a connection between CSST’s (Specialized Care Centres for Drug Addicts) and CCAA’s (Outpatient Alcoholism Treatment Centres), through the creation of new CSAPA’s (Centres for Treatment, Assistance, and Prevention of Addiction).

From a repressive point of view, the status of tobacco, alcohol, and psychotropic medicines has not changed, of course: the availability and the use of such substances are licit yet regulated. However the legal and statutory status pertaining to these substances has been gradually strengthened, following a trend that began in the early nineties.

The effective rendition of such conceptual discriminations in public policies orientation was one of the major novelties of that period, although integrating alcohol especially, then tobacco in the framework of drugs was subjected to a strong hostility, because of the cultural and economical import lent to wine, and the weight of economic interest attached to the tobacco industry.

The current Government Plan for the Fight Against Illicit Drugs, Tobacco, and Alcohol, approved in July 2004, reiterates the fact that licit substances are accounted for within the domain of the fight against addictions (MILDT, 2004). Following the Triennial Plan, the 2004-2008 Plan of Action acknowledges *“the results from the research, and the evolutions within the modes of use and the populations concerned”* (p. 5), and suggests *“a pragmatic approach for each substance”* (p. 6), that unfolds in terms of prevention, information, care, and repression. The five-year plan underlines the difficulty to *“express through action the full approach concept”* (p. 5) noticed in the evaluation report on the triennial plan (OFDT, 2003, see also the next section in the article), and asserts a determination to *“take advantage of*

⁶⁰ Notion referring to a type of use that can be described as causing damages relating to a recurrent use with no signs of an addiction. Such a category matches the definition of “abuse” in the DSM IV (Diagnostic and Statistical Manual of Mental Disorders – 4th Edition) and the one of “harmful use” in the ICD 10 (International Classification of Diseases – 10th Revision).

such an approach in the areas where it could prove useful, without making it the leading principle of its action” (p. 6).

In other words, the government plan puts forward strategy main lines for each substance and prevention has been granted a major position, while reasserting that *“the early age for uses stands for an additional aggravating factor”* (p.6). Consequently the common prevention purpose is to prevent and delay the experimentation age for all potentially addictive substances, tobacco and alcohol in particular, which have a *“very strong sanitary impact due to the long-lasting characteristic of these uses during a lifetime, their social and cultural dimensions, and the risks of serious pathologies they are connected with”* (p.6). Given that line of attack, the youth population is a particular target of the plan preventive action.

These priority purposes aiming at undergoing a *“resolute fight on all fronts [...] against tobacco”* (p.5) and dealing with the *“still too lenient approval of alcohol-related nuisances”* (p.5) operate through thematic parts (with precedence allowed to prevention) and match quantified evaluation indicators (cross-referred to the annex to the plan).

About alcohol-related problematics, such a plan intends to cut down 20% of the average alcohol use per capita, in accordance with the WHO (World Health Organization) standards acknowledged by the August 9th, 2004 Public Health Law (August 11th, 2004, n°185). That goal suggests to develop courses of action aiming at decreasing levels of use in order to follow WHO “moderate uses” thresholds (no more than 2 glasses⁶¹ of alcohol a day for females, 3 for males; no more than 4 glasses for a sporadic use, and refrain from any alcohol use whatsoever at least once a week). It also implies drunkenness reduction, alcohol total abstinence during pregnancy and activities involving accident risks for oneself or other people. As a result, it is a many-sided strategy, coherent with the 2002-2004 alcohol action strategy of the General Health Department (Direction générale de la santé (Ministère de la Santé), 2001):

- Within the realm of prevention, the plan is based upon several courses of action: an intensive public communication issuing markers of a moderate use, and supported by messages matching different categories of drinkers or having various modes of use; actions for preventing accidents; developing health education at school; effective enforcement of statutory measures aiming at creating a context favouring a lower use (enforcing the ban on selling to minors, legal watch) or the implementation of new policies; detecting risk uses in primary care services, motivating and helping drinkers to reduce their alcohol uses;
- In terms of information, training, and communication: training general practitioners to early screening and brief intervention among excessive drinkers;
- About care: improving its accessibility, quality, and efficiency (with a specific consideration for incarcerated users), preventing relapses, and heightening the public awareness of alcohol-related risks during pregnancy;
- As far as law enforcement is concerned: respecting statutory rules pertaining to alcohol, which, according to the terms of the plan, must be developed and more severely respected;
- Concerning knowledge development (research and observation), in order to document use behaviours, screening alcohol abuse or addiction as soon as possible.

The Government Plan echoes the 2003-2007 National Plan for the Fight Against Cancer aiming at reducing tobacco uses (MILC, 2003). Its goals within five years unfold as follows:

- Decreasing experimentation and delaying its age from 14 to 16 years-old;

⁶¹ The term “glass” refers to a “standard glass” or the international alcohol unit, that stands for 10 g of pure alcohol.

- Encouraging an earlier smoking cessation;
- Reducing tobacco use among pregnant women from 29.5% to 20%;
- Cutting down passive smoke exposure.

The action program envisioned to reach such goals consists in combining action with availability (in raising taxes, restricting advertising, operating selling restrictions to minors under 16, and favouring a “smoke free” school, or even in organizing a communication campaign) whose action aims at a better enforcement of regulation restricting tobacco use in public places, in order to protect non-smokers and have a deterrent effect upon smokers.

Therefore the actions relating to the fight against tobacco use are based upon several purposes:

- Prevention (to avoid or delay the first cigarette ever smoked, to encourage and help smokers to quit smoking, to protect non-smokers);
- Information, training, and communication: the help line number of DATIS (Drugs, Alcohol, and Tobacco Information Service) has been replaced by several others according to the substances (e.g.: Tabac info service), in order to provide callers with a specific and personalized information, and a possible orientation. The plan requires future communication campaigns and the improvement of health professionals training about specific problems relating to quitting tobacco smoking;
- Care: lines of operation suggested in the plan consist in supporting care experiences with reimbursement of nicotine substitutes, and the development of consultations to help smokers to quit tobacco;
- Respect of legislation (support the evolution and the enforcement of tobacco-related laws);
- Develop knowledge (research and observation): improve knowledge on patterns of use, inferred social and health damages, as well as prevention and health education methods;
- Fight against smuggling: the government plan aims at strengthening the fight against organized cigarette trafficking and illicit retail sale observed in some French metropolis (Marseilles, Toulouse, Paris), notably since the consecutive rises on cigarettes prices.

The whole orientations and quantified purposes included in the five-year plan have been defined in accordance with the basis of the national public health policy, stated in the August 9th, 2004 Public Health Law, which aims at providing the country with the necessary structures and procedure to set up a bold policy of health protection and promotion for the population (Journal Officiel, August 11th, 2004, n°185). Among the “100 public health goals” selected next to the national consulting, a “quantifiable target” can be found for each one of both substances. More precisely:

- Reducing prevalence of excessive alcohol use, and preventing addiction to settle (by a 20% decrease in the yearly use of alcohol per capita, that is from 10.7 l/year/capita in 1999 to 8.5 l/year/capita by 2008) ;
- reducing passive tobacco smoke exposure in schools, leisure places, at work (with a view to decrease the prevalence of daily smokers’ tobacco use from 33% to 25% among males, and from 26% to 20% among females, by 2008).

Psychotropic medicines are not specifically and explicitly referred to: they are nevertheless mentioned several times, following the theory according to which psychotropic medicines are included in the realm of substances whose use and harm are to be fought against, as defined in the courses of action of the previous plan.

Concerning doping prevention, the plan aims at operating within sports environment (among the youth and executives in particular) actions of training, public-awareness campaign, and personalized prevention. The targets attached to such actions are:

- To contribute to the training of health and education professionals, and to operate among the various sports populations;
- To strengthen sports instructors' expertise in prevention, screening, and guidance of young users;
- To help young athletes to be independent in deciding their use behaviours, and likely to ask for support.

Besides, following the benefits from the previous Triennial Plan, the 2004-2008 Government Plan sets several cross-reference goals for the whole substances, referring to the notion of "addiction": improving health system efficiency in screening and treatment, through enabling the creation of addictology reference centres; promoting addictology as a support for education, teaching, and research.

Lastly, although the issue on integrating the "addictions without substances" in the MILDT field of action repeatedly triggers off debates in the press or among addiction experts, that topic is not subjected to a real public policy in France. During the 1998-2002 period, thought has been given to the matter, including in particular pathological play, Internet or video games excessive use, obsessive purchase or diet behavioural disorders as bulimia and anorexia. Such a thought relied on the conclusions of experts, who consider Internet or video games addictions echo patterns similar to those of drugs, and require close therapeutic responses. Such emerging debates do not translate in institutional changes.

Genesis and Rationale

The broadening of national strategy for the fight against drugs to licit substances in 1999 relied on scientific knowledge acquired, in particular on recommendations included in recent reports (Comité consultatif national d'éthique pour les sciences de la vie et de la santé sur les toxicomanies, 1994; Parquet, 1997). It translated in separate strategies through both government plans approved since then. Given the weaknesses known in the French fight against drugs, a number of required evolutions has been outlined, leading to amend the prevention and care policy conducted in France until 1999.

The extension to licit drugs relied upon several major conclusions⁶²:

- The modes of use evolution showing a stability (even a decrease) in heroine use, a rise in cannabis use, a more and more important access to synthetic drugs, a gradual frequency of abuses combining licit and illicit substances;
- Meanwhile a dramatic increase in the use of strong alcohol among youngsters with recurrent drunkenness, of psychoactive medicines as in all developed countries, and a trivialization of doping substances;
- The most recent surveys would show a common molecular basis for all addictions;
- The difficulty to match both repression and health care actions.
- The lack of diversification of the drug addicts specialized care system, comparatively developed in its still strong direction towards individuals addicted to opiates;
- The lack of care for individuals having alcohol difficulties and tobacco users, when considering the significance of populations concerned;

⁶² According to the assignment of N. Maestracci, then MILDT Chairwoman, setting the goals of the RASCAS working party, instructed to run the thought about the common and specific aspects in the uses of various psychoactive substances.

- The late screening of drug abuse and access to care;
- The multiplicity of financing and the lack of territorial programming in the prevention and care facilities, leading to strong disparities
- The comparatively secretive behaviour in the public care structures (general medicine, hospitals) facing drug users.

The Report on Drug Addictions by the National Committee for the Health and Life Sciences (1994) was the first to meaningfully question the distinction – regarded as pharmacologically biased – between licit and illicit drugs, considering it did not rest on any scientific or practical basis. The report drew attention to the value of prevention, underlining that drug users health, whatever the legal status of the substance, should come first. Following such conclusions, the Parquet Report, labelled “For a Prevention Policy Pertaining to Psychoactive Substances Use Behaviour” (1997), underscored the fact that the evolutions of drug problematic would require more pragmatic solutions than a lecture about abstinence, similar to the one that had been told for nearly three decades. Reasserting the common neurobiological effects of licit and illicit substances on psyche and the psychosocial and environmental influential factors of addictive behaviours, the report concluded that the use behaviour determined the risk, more than the substance itself, and separated harmful use from addiction. It suggested an appropriate preventive message, intended for psychoactive substances, a generic term including illicit drugs, alcohol, tobacco, and psychotropic medicines.

The behavioural approach recommended in that report also claimed a distinction between use, abuse (or harmful use), and addiction, which already appeared in reference international classifications (especially in the 10th version of the International Classification of Diseases – ICD 10 — of 1992, or in the 4th version of the Diagnostic and Statistical Manual of Mental Disorders — DSM IV — of 1994), whose improvement was to integrate a psychopathological dimension breaking off from a usual behaviour of the subject. While supporting the observance of the “traditional” goal of prevention policies — avoid initiating the use of psychoactive substances —, the report would suggest a course of action that was supposed to go beyond that, in preventing also the development from use to harmful use or addiction.

Along that line, Pr. Parquet’s thought stands for a significant advance in the preventive approach: it actually suggests to build the prevention strategy on a program logic in order to set up varied purposes, coherent with the populations specific needs. Besides, the development of a common culture — established as a goal in the 1999-2001 triennial plan — is presented as one of the essential modes of the quest for a consistent language between various contributors acting within the realm of prevention (government services, professionals, media, consumers group or other communitarian groups). The conclusions of that report have then been included in the development of a discriminating prevention strategy, which covers the whole substances and separates the levels of use.

Relying upon such elements of scientific knowledge, one of the main features of the triennial plan was to extend the government program to alcohol, tobacco, psychoactive medicines, and doping substances; yet that does not mean that all substances have been considered the same way from the angle of law, care, or prevention. The action strategy has not been split according to various substances: it has built its lines of action in accordance to use behaviours, judging there were more common points between licit and illicit drugs than peculiarities for each substance. Following such reasoning, the reference to the “addiction” concept has been mostly developed. The five-year plan has moderated that bias in favouring one approach for each substance, while borrowing the cognitive patterns from the global approach.

Converting that “global approach” concept into action from 1999 onwards has been remarked and debated in the evaluation report of the triennial plan, conducted by the OFDT (2003). It considers that the notion has proved more complex and difficult to put into practice than it seemed. While the attempts to build a common culture on the whole public responses and

psychoactive substances have born fruit, the report however reveals that prevention, care, and repression have had some difficulties in making the global approach operational:

- In the realm of prevention, as far as social communication and field actions are concerned, global approach directed to users behaviours rather than to substances has not succeeded in specifying its operational purposes. The possibility to express general messages likely to reach specific targets, in terms of populations or substances, has come up against difficulties when being converted into action.
- In the realm of care, the use of global approach, supposed to lead first to defining concrete modes of care accounting for what is common or specific to the different substances, and eventually to administratively harmonizing structures, has shown its limits, failing to adequately put together practices and medical responses.
- In the realm of repression at last, global approach has not been able to free itself from the condition of laws. The plan has not lead to amend legislation: neither generalized prohibition on all drugs, nor exclusive rule of controlled legislation. Alcohol, tobacco, and psychotropic medicines remain substances whose availability and use are not banned. Narcotics being always illicit, global approach translates in the desire to substitute a larger lexicalisation for standard repression, as far as illicit drugs are concerned, in particular for cannabis, and for penal consequences relating to alcohol abuse.

While global approach has opened up the age of the indiscrimination of substances, its implementation immediately perceptible appeared restricted within the period when the triennial plan was enforced. This being said, the evaluation report of the plan asks the following question: how could it be otherwise? The five-year plan (2004-2008), without questioning the rationale of global) approach, a chosen to favour an approach per each substance. The MILDT has therefore centred its goals and sphere of activities back to the most massive uses in general population (alcohol, tobacco, psychotropic medicines, cannabis). Cannabis has been notably targeted in the line of action, following the assumption according to which that substance would be commonplace among youngsters.

Furthermore the principle of extending the notion of drugs to licit substances does not seem unquestionably acquired. Accordingly when the present five-year plan was issued, and in the following period, integrating alcohol in the field of drugs had been debated again, in accordance with the specific status granted to wine. During the Parliament debates on the bill relating to rural territories development in October 2004, senators had brought down the wrath of anti-alcoholic associations, when presenting for the first reading of the bill a set of exceptional arrangements to the Evin Law, allowing in wine advertising references to its "sensorial and organoleptic qualities". During discussions, some Members of Parliament claimed a "sacred union around wine" and called for a "truce in the unconditional attacks against it". The question of suppressing the compulsory mention about alcohol dangers to health on alcohol bottles was even asked during session.

On behalf of the significance of wine uses in France, and their cultural dimension, as well as for preserving the economic interests of the wine-producing careers (600 000 professionals), wine has, among alcohols, traditionally be granted a special rule: for example, it is the least taxed alcohol, as its taxation is 32 times lower than the one imposed on strong alcohols.

The jeopardizing of such a status by alcoholology experts, claiming an unconditional fight against alcohol addiction, regularly triggers off violent protests from wine producers and retailers, relayed by Members of Parliament elected in rural constituencies subjected to the ascendancy of wine producing areas. Such a controversy was brought to a close when, in January 2005, during the second reading of the bill on rural territories, a compromise amendment was voted, which described the rules relating to wine advertising: the latter can

include references and images featuring the production areas, rewards obtained, original labels and their components, or geographical indications right-protected. It must be restricted to the product description (but not the act of use and its effects), provides objective (but not subjective) indications in order to inform (and not to promote). Such an example nevertheless illustrates the ambiguities of a “global” public policy, cornered between a public health logic and an economic and commercial one, both contradictory.

The doping issue became the focal point of political debates in 1998. Such a context enables its integration in the MILDT line of operation. A collective appraisal labelled “doping and sports practices” had been actually performed by the CNRS (National Centre for Scientific Research) on the sociological, psychological, pharmacological, and toxicological aspects of pathologies associated with doping, whose step report issued in August 1998 conveyed a number of recommendations aiming at prevention (Escande and Roussel, 1998):

- To develop research on the existing connection between doping and drug addiction;
- To initiate on a French and European level the “sports practice” piece of information in the pharmacovigilance inventory systems;
- To ask officially the AFSSAPS (French Health Products Safety Agency) to demand specific surveys among sportspeople, when applying for a MA (marketing authorisation) of new products likely to be used as doping substances;
- To initiate epidemiological surveys whose target is to evaluate the extent of the doping phenomenon and the gravity of its consequences upon the athletes’ health in the short, medium or long term;
- To set up compulsory classes on doping for health professionals within the realm of their initial and permanent training.

A number of governmental acts have then been put for answering such an issue (September 10th, 1998 Order; July 2nd, 1998 Order; Journal Officiel, July 21st, 1998; June 10th, 1998 Decree n°98-464, Journal Officiel, June 17th, 1998) in order to adjust the existing legislation arsenal for doping substances prevention and repression in sports competitions and events.

Responsibility and Expertise (Coordination)

Since the approval of the August 1st, 2001 Organic Law Pertaining to Finance Laws⁶³ (LOLF), a new administrative and budgetary organization has been approved (Journal Officiel, August, 2nd, n°177). According to that reform, the Chairman of the MILDT — attached to the Prime Minister — is responsible for setting up the “Drugs and Drug Addiction” program. For 2005, the MILDT has been granted 38 million euros, distributed around three main lines of action to fight illicit drugs, tobacco, and alcohol: interministerial coordination of the preventive, health care, and repressive areas; experimentation of new partnerships devices in prevention, care, and law enforcement; and lastly, international cooperation. Such a program, belonging to the Government Health⁶⁴ Mission fits nevertheless in a strong interministerial context, as the fight against drugs (tobacco, alcohol, and illicit drugs) involves about twenty of ministerial departments. In addition, it must also gather local communities

⁶³ The January 2nd, 1959 Decree pertaining to the Organic Law relating to Finance Laws — which has been fully abrogated on January 1st, 2005 — would describe the expertise and powers of Government and Parliament for the State Finances. The thought being engaged in Parliament, during the years 1998-2000, about the efficiency of public expenditure and the role of Assemblies in budget, saw the emergence of a consensual political desire to update budget and accounting rules, decided by the 1959 Organic Decree. Setting up the new financial constitution only lasted four years, from its promulgation in 2001 until the vote for the 2006 Finance Law to the new regulations.

⁶⁴ Within the framework of the 2005 Finance Bill, and according to the 2001 Budget, the Health Mission includes three other programs: Public Health and Prevention, Care Accessibility and Quality of the Care System, Conception and Management of Health Policies.

and associations around the goals of the government plan, which stands for the reference framework of the program.

The MILDT coordinating role revolves around all initiatives necessary to conduct ministerial actions serving a coherent policy for fighting illicit drugs, alcohol, and tobacco.

- Both the law, as well as and the health and social awareness of harmful behaviours must be reasserted, through cross-category training common to the different contributors to prevention (police, gendarmerie, school and sports club staff).
- The MILDT research program must be relied upon, as its main concerns are described by a scientific committee, and it allows calls for papers among public research centres, having collective expert appraisals enabling all ministries to get the same information about the level of scientific knowledge on the health risks and consequences of use.
- Coordinating communication campaigns funded by the MILDT only depends on the INPES (National Institute for Health Prevention and Education). The alcohol program aforementioned aims at promoting a low use and alerting on the risks in relation to a regular alcoholization. The communication already planned by INPES for the 2004-2006 period relies upon TV campaigns and actions outside the media. Together with the “general public” conducted by the INPES, numerous prevention services develop tools for their actions or suggested to field contributors. The MILDT labelling of such tools certifies the soundness of information and the preventive value of contents.
- As far as care is concerned, the treatment system depends on planning care availability on a regional level, even if its distribution remains imbalanced. The development of care accessibility for individuals with alcohol issues is still “very deficient” (p.31), according to the terms of the five-year plan. The identified deficiencies concern care accessibility in some geographical areas, coordination between structures, notably between general medicine and specialized departments, as well as the treatment of associated psychiatric disorders. One of the lines of improvement suggested by the plan consists in reorganizing the CCAA’s (Outpatient Alcoholism Treatment Centres), and the CSST’s (Specialized Centres for Drug Addicts) within the framework of medico-social institutions called CSAPA’s (Centres for Treatment, Assistance, and Prevention of Addiction). Such centres could offer treatment either simultaneously for several types of addiction, either exclusively for problems with alcohol or tobacco (notably). Activities relating to alcohol, tobacco, and other substances must be defined in the establishment project, within the realm of distinct programs (detailing the therapeutic project, consultation hours, staff appointed to it, etc.). The CSAPA’s can be developed on one unique site or develop various structures through a network. Besides, the present range of connecting teams in addictology (created within the framework of the previous plan) “still meets unsatisfactorily the needs” according the current government plan (p.34). Such teams are supposed to assist hospital nurse staff for the screening and treatment of patients experiencing abuse or addiction problems, and to develop care procedures for the latter during hospitalisations. These teams should be present in all French départements, in order to strengthen the existing staff.
- Protecting non-smokers requires a better enforcement and control of the current legislation restrictions, in reasserting the dissuasive value of the Evin Law. Such a task involves a coordinate action from several ministries, whose guiding is a

priority line of the “Drugs and Drug Addiction” program. In this respect, the Prime Minister had specifically asked the MILDT, through an assignment letter, to pilot the whole banning on smoking in public places, in order to improve the acknowledgment of the Evin Law.

In terms of local supervision and territory network, priorities defined on the national level are relayed on the territorial level by chief coordinators and “drugs and drug addiction project managers” in each French départements. These project managers are being asked to coordinate, under the prefect’s authority, the actions of local services over the whole drug field. Their mission translates into territory programs revolving around:

- Département conventions on purposes, agreed between prosecutors and the DDASS (Direction of Health and Social Affairs at local level - for the Département), in order to provide users in the hand of justice with a health and social care, and offer an alternative to legal action;
- Preventive actions in and around school, for which they will particularly have to see that messages and actions directed to the youth should be validated, coherent, and including all legal, health, and social aspects;
- Local actions relating to the enforcement of the Evin Law in public places;
- All actions included in the main lines of the government plan.

To provide these project managers and coordinators with a technical support, the CIRDD’s (Centres for Information and Resources on Drugs and Drug Addictions) have been created, and their missions of guidance in methodology, observation, and documentation must meet every courses of action of the government policy. This CIRDD Network, acknowledged by the MILDT, is presently incomplete and heterogeneous, and reorganizes itself on a regional and sometimes interregional level, in order to meet local needs and enable a pooling of resources.

As a conclusion, it must be underlined that MILDT has no authority to play a direct part in the organization of various problematics connected with the fight against illicit drugs, alcohol, and tobacco, but to impulse and coordinate the different contributors in providing them with the necessary tools to conduct their courses of action.

May, 2005

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13. Drug Use in French Recreational Areas: Situation in 2004 and Recent Evolutions

Introduction

Attending parties, recreational moments and venues often give people opportunities to use licit or illicit psychotropic substances. Ever since it has emerged by the late eighties, the techno party scene has been associated with the use of psychoactive substances, notably stimulants as the MDMA that is the ecstasy molecule. Even if extreme behaviours may be observed in different recreational areas, the use of illicit drugs appears to be at a quite low level when surveyed (Aquatias *et al.*, 2001). In 1999 a significant study coordinated by the Médecins du Monde Rave Mission has enabled describing many aspects of the techno area, and objectivized, among other things, the frequent uses of psychoactive substances (Sueur and Bastiannelli, 1999). This paper presents a global picture of licit and illicit drug uses within the French techno scene in 2004, and some evolutions having occurred for last years.

The data used comes mostly from two sources: the OFDT TREND facility and a quantitative survey among users from the “electronic music” recreational area, carried out in 2004 and 2005.

Since 1999 within the realm of the TREND (*Tendances récentes et nouvelles drogues*; New Tendencies and New Drugs) facility set up by the OFDT (*Observatoire français des drogues et des toxicomanies*; French Monitoring Centre for Drugs and Drug Addiction), the techno party scene has been defined as one of both main observational fields (Bello *et al.*, 2004). The techno party scene includes areas where techno culture events take place, as discotheques, teknivals, *free-parties*, rave-parties, pubs promoting themselves through electronic music (“urban parties”), private parties... Such an area registers a high prevalence and incidence in the uses of psychotropic substances. A multicentre network of observers helps depicting an annual picture of the substances used, modes of use, and users⁶⁵ profiles.

To complete this qualitative observation, a quantitative survey has been operated in 2004 and 2005 among individuals attending the “electronic music” recreational area. A mapping of the latter has been carried out thanks to a collection of ethnographical data. Such a preliminary enables an artificial restoration of a sampling method based upon a typology of four subpopulations (*free/rave*, urban parties, clubbing, and “VIP parties”). In the second place data has been collected among users through a face to face questionnaire. Nearly 1,500 individuals have been surveyed in five urban centres (Bordeaux, Metz, Nice, Rennes, Toulouse) (Reynaud-Maurupt *et al.*, 2004).

Prior to these results, a reminder of the legal framework pertaining to techno culture recreational events and the risk reduction actions for individuals using psychotropic substances is given.

French Legal Framework

Laws and regulations for techno culture recreational events

Until the end of 2001 rave parties and *free-parties* would take place regardless of any specific regulation. The new Clause n° 23-1 within the Orientation and Programming Law Pertaining to Security (issuing from the 2001-1062 Law of November 15th, 2001) has offered a new legal framework to such meetings. Ever since the organizers have been bound to declare their projects to the prefects of the départements where rave parties are planned.

⁶⁵ For more information about the methods used for observation, see (Bello *et al.*, 2004, pages 23 to 30).

The 2002-887 Order in Council of May 3rd, 2002 specifies the submission modes. Individuals organizing musical recreational meetings within areas unfitted for must then declare them to the département prefect one month before the date planned, as far as such gathering meets the following requirements: amplified music broadcast, more than 250 people taking part including managers, gathering publicized in the media, billboards, flyers or any means of communication and telecommunication; risks likely to threaten the safety of people taking part due to the lack of facilities and the layout of the premises. Such declaration must be submitted with a permission to take possession of these premises delivered by the owner or the holder of the real right of use. It must describe the arrangements planned by the managers to provide for safety and health to people attending the events, public health, sanitation, and without any public disturbance. Failing to respect the declaration requirement or organizing a rave party in contravention of a prefect-issued banning is liable to a € 1,500 fine. As a supplementary sentence, this Order of Council makes provision for a suspension of three years or more of the driving licence, confiscation of “the device which was used or likely to be to commit the offence, or the device issuing from it”, 20 to 120 hours of community service order.

Actions for risk reduction in recreational areas

The Clause n°12 within the August 9th, 2004 Public Health Law registers the risk reduction policy for drug users in the Public Health Code. It then falls within the competence of the government and is officially defined as aiming to “*prevent infection dissemination, overdose mortality by drug intravenous injection, and the social and psychological harms relating to drug addiction by substances listed as narcotics*”.

An Order of Council issued in 2005 (n° 2005-345, in April 14th, 2005) details the national reference framework of the risk reduction actions towards drug users.

Therefore the purposes of such risk reduction activities are the following:

- Prevention of serious, acute, or chronic infections, notably those issuing from sharing the injection equipment;
- Prevention of acute intoxications, primarily lethal overdoses issuing from the use of narcotics or the combination of the latter with alcohol or medicines;
- Prevention and care for acute psychiatric disorders in relation to such uses;
- Guiding individuals to emergency, general care, specialized care, and social services;
- Improving physical and psychological condition, and rehabilitation for drug users (accommodation, access to social services and facilities mostly)

Several methods of intervention are brought up, such as:

- To contact people in the areas attended by the target population;
- To distribute and promote sanitary and prevention equipments;
- To inform about the risks related to drug uses and their prevention;
- Individualized guidance;
- To turn to and/or to take people to general or specialized care structures;
- To give access to rest facilities, to distribute drinks and food;
- To nurse;
- To retrieve used equipment and to process septic waste.

These texts offer a legal framework to risk reduction actions that have been developed for several years by various associations in the techno party scene (Techno plus, Médecins du Monde, ASUD, etc.), while banning other actions as colorimetric reaction *testing* (Marquis

Test). As they have been recently issued, their impact on these actions is yet to be assessed.

Techno party scene evolutions

The aforementioned legal policies, whose enforcement has begun in the middle of 2002, have inferred several alterations within the French techno party scene.

In 2002 and 2003 six major evolutions have been observed:

- Non-commercial techno events (free-parties) have become scarce, even disappeared in some locations, while private events have increased;
- Recreational techno events have been organized in partnership with some venues;
- Development of private parties gathering less than 250 individuals and not liable to be officially declared to a prefecture;
- Increase of club and disco attendance;
- Increasing attendance of French techno party goers in techno events organized in border countries (Belgium, Spain, Italy, Germany);
- Redirecting of drug trafficking towards new recreational locations.

The scarcity even near-disappearance of *free-parties* seems mostly due to the actions of the police, who are now allowed to disperse recreational gatherings when no prefectorial agreement has been granted to organizers.

Private parties have been more and more observed in most Metropolitan locations. Individuals can organize them at their own places provided they have space enough either in public forest places (free admission or donation) or in some rented premises (in which case there is often an admission fee). Organizers frequently come up against the reluctance of possible lessors. Such parties are not subjected to media coverage. They partly attract the typical *free-parties*/teknivals attendance which is informed through acquaintance network.

Techno parties in clubs and discos have been developing during last years, and the uses of substances can easily be observed there. Simultaneously the actions of the police in such venues have been reported, and several times resulted in lawful closing of clubs and discos. Furthermore club and discotheque owners would strengthen checking out for admittance and inside their venues, while adding force to their own security services: *“in such circumstances, there is an added pressure from club security services, and searching at the admittance point to these venues would have become stronger and more intrusive than before (checking out ID’s, distribution of flyers stipulating that being in possession of drugs is prohibited, search”* (Bello et al., 2004).

The third opportunity offered to *teuffeurs*⁶⁶ is to cross the border in order to find locations devoted to their favourite parties. Border country observers from the network report increasing weekend migrations to Belgium, Spain, or Italy in clubs, discotheques, or *free-parties*. Therefore young Northerners can go dancing in Belgian “mega-dance halls”, whereas youngsters living in South-western France will visit Spanish techno parties. Border countries *“seem to be special welcoming areas for that kind of party, whose major attendance ratios belong to French nationals”* (Bello et al., 2004). Some observers from Toulouse report migrations to more distant countries as the Czech Republic and Croatia, which would become much favoured by *free-parties* goers, mainly in summer period. Such a group would include unwavering individuals who do not acknowledge the institutionalization of the techno movement that goes alongside the disappearance of “unofficial and free” parties to the benefit of commercial events, teknivals approved by the Ministry of the Interior, or private parties.

⁶⁶ *teuffeurs*: partygoers in French verlan (reversed language).

Considering that *free-parties* have become scarce, traffickers seem to have partly redirected their ways to clubs and discotheques. On the other hand, because of massive police actions associated with those of some owners, many traffickers have changed their habits and avoid dealing openly within venues. In some locations dealing occurs outside nearby clubs and discotheques, in the street and parking lots close to recreational areas. In parties people tend to come with the substances they need and not to buy them on the spot any longer. This is obviously the case in clubs and discos yet also in “micro-parties” organized by individuals. In the remaining *free-parties* most of observers have noticed that trafficking is more cautious, sales by auction tend to disappear, and dealing operates within users themselves, unlike a recent period when dealing could be carried out by “specialized” pushers.

Who are the recreational area users?

During last decade the population interested in techno culture and parties has been notably changing and spreading. While gathering at first groups of people often focusing on somewhat anarchistic political values, it then “normalized” as it developed. Whereas small groups keep alive the “temporary autonomous zone” original attitude, most of people are attracted to innovative music with a fairly rebel flavour.

While the first techno followers are over forty years of age by now, most of the individuals attending the techno scene remain young adults. In the “electronic music” survey the respondents were between 16 and 52 year-old yet the average age was 24 years and eleven months old. The latter would vary according to the recreational area concerned: between 23 years and 1 month old for *free-parties* and up to 26 years and 8 months for “VIP parties”.

Such a setting still remains chiefly attended by males, as females would stand for a bit more than one third (36%) of the surveyed population. Such a ratio slightly fluctuates in accordance with the recreational area concerned: from 34.0% for *free-parties* to 38.6% among clubbers.

As it can be reasonably expected for young adults, most of the respondents (77.6%) are single and only 8.8% of them have one child or more in their cares. While more than two thirds (68.5%) have a home of their own, nearly one fourth (24.2%) are still living at their parents’. Only a minority (2.3%) acknowledge precarious housing conditions or none at all.

Their occupations do not seem to discriminate themselves dramatically from the rest of the French population within that age-bracket. More than half of them (58.2%) are involved in salaried employment, one fifth (20.1%) are studying, but nearly one tenth (9.7%) are non-working or unemployed. This is a population with low means of support. More than half of them (53%) earn below € 1,000 monthly. The greater majority (98.9%) have a social security cover.

Substance uses

Among the users attending the “electronic music” recreational area, higher levels of experimentation (at least one lifetime use) of the main illicit substances (cannabis, ecstasy and amphetamines, cocaine, hallucinogenic mushrooms and LSD, poppers) can be observed when compared with those of 15-34 year-olds in French population (Table 38). However the uses remain infrequent or sporadic for some substances.

Ingesting, sniffing, and smoking stand for the main modes of administration of these substances. Injection is still regarded as a degrading mode by individuals attending the recreational area and only practiced by a minority.

Among the respondents of the “electronic music” survey two thirds of them (66.0%) have tried sniffing, and four out of ten (40.7%) have resorted to it during the previous month. While nearly one individual out of twenty (4.5%) acknowledges having injected him/herself a

substance, only one out of two hundreds (0.5%) has done it during the month prior to the survey.

According to SINTES (*Système d'identification national des toxiques et des substances*; National Poison/Substance Identification System, run by the OFDT), pills and blotting papers collected in 2003 are almost exclusively meant to be swallowed. As for powders, 3 samples out of 4 are meant to be sniffed (74%). On the whole less than 1% of the substances collected within the realm of SINTES are meant to be injected.

Table 38: Frequency of lifetime use and previous month use among recreational area users, and lifetime use among 15-34 year-olds

	Recreational area users, 2004			15-34 Year-olds, 2002*
	Respondents	Lifetime	Previous month	Lifetime
Tobacco	1496	-	87.4%	-
Alcohol	1496	-	96.0%	-
Cannabis	1496	93.6%	68.5%	30.0%
Ecstasy	1494	67.7%	32.4%	1.9%
Cocaine (unbased)	1488	62.6%	34.8%	3.0%
Hallucinogenic mushrooms	1481	54.9%	12.6%	2.1%
Poppers	1470	50.6%	10.4%	UNAV
Amphetamines	1492	46.8%	13.4%	0.1%
LSD	1488	45.4%	10.6%	1.5%
Opium & rachacha	1482	28.3%	4.3%	UNAV
Heroin	1474	23.1%	6.8%	0.5%
Crack / free base	1458	20.6%	6.2%	UNAV
Ketamine	1484	16.4%	2.4%	UNAV
Unprescribed benzodiazepines	1420	9.5%	1.9%	UNAV

UNAV: unavailable

Sources: survey on "electronic music" GRVS/OFTD and * EROPP 2002, OFDT.

The various family of substances

Alcohol, tobacco, cannabis

These three substances strongly come about in recreational areas, such as live concerts, festivals, clubs, discos, rave parties, *free-parties*. Trends can hardly be assessed in such locations considering their strong prevalence, and the lack of recurring and comparable quantitative data.

Alcohol and tobacco

In 2004 among the users of the "electronic music" recreational area, nearly all of them (96%) have drunk alcohol during the month prior to the survey. A bit less than one individual out of ten (8.2%) acknowledges a daily use. On drinking days, a majority (50.7%) use more than four glasses of alcohol, and the mean number of drunkenness amounts to 2.3 per people. Among the 3,500 individuals contacted through Parisian gay venues, 15% declare a daily alcohol use and many times a day (Le Kiosque *et al.*, 2005, see also Section 2 in National Report).

A great majority (87.4%) of the users attending the "electronic music" recreational area have smoked tobacco during the month prior to the survey. Most of them are daily smokers, among which more than one fifth (22.1%) smoke more than 20 cigarettes a day.

Cannabis

During the month prior to the survey, this substance has been used by more than two thirds (68.5%) of the individuals surveyed within the "electronic music" recreational area; more than

once a week by 58.4% of them, and on a daily basis by more than four respondents out of ten (41.4%). It can then be observed that cannabis daily use is more frequent than drinking alcohol in such a population. Among the 3,500 individuals contacted through Parisian gay venues, 35% of them declare using cannabis with alcohol on a “regular” basis.

Stimulants

In France, stimulants stand for the most used family of substances within the realm of recreational area. Their use seems to register a steady development ever since 1999.

Cocaine hydrochloride and based cocaine

Cocaine can be either used in its powder form (cocaine hydrochloride) or its smoking counterpart (based cocaine) whose main naming is “free base” in the recreational area.

Cocaine hydrochloride is a substance whose distribution in Metropolitan France — within the recreational area yet also outside it —, has begun since several years ago and is still carrying on nowadays. Describing a standard profile for the cocaine powder user proves difficult because of the great variety of social profiles among users, which can include very marginalized people as well as very high-income individuals. Such a distribution is associated with an increasing availability of that substance, as well as its positive image perceived by the users: “luxury substance”, “substance to have a wild time”, “substance for recreational activities”, “cure-all substance”.

In 2004, within the “electronic music” recreational scene, cocaine hydrochloride has been experimented by almost two thirds (62.6%) of individuals. From one individual out of two (48.4%) for the “VIP” area to more than eight out of ten for the free/rave area. More than one individual out of five (23.0%) has used that substance during the month prior to the survey, and more than one in ten (11.8%) twice or more on a weekly basis. The administering modes include sniffing (82.9%) and sometimes smoking (16.2%). Injection remains fairly occasional (0.5%). Among 2,860 contacted through Parisian gay venues, 21% of them declare having used cocaine with alcohol during their lifetimes, and 5.6% admit doing it regularly and systematically (Le Kiosque *et al.*, 2005).

The use of “crack” or “free base”, a based and smoking form of cocaine, increased in the recreational scene at the beginning of year 2000. Such an expansion was related to the possibility to use crack inconspicuously in smoking it when combined with a joint, quicker effects than those of sniff, and its availability in some locations. However that increase seems to have stopped ever since 2003.

In 2004 free base has been experimented by 20.6% of users attending the “electronic music” recreational area. Recent users (during the month) are fairly uncommon (6.2%). It should sound logical that almost all uses (97.8%) operates through smoking.

Ecstasy

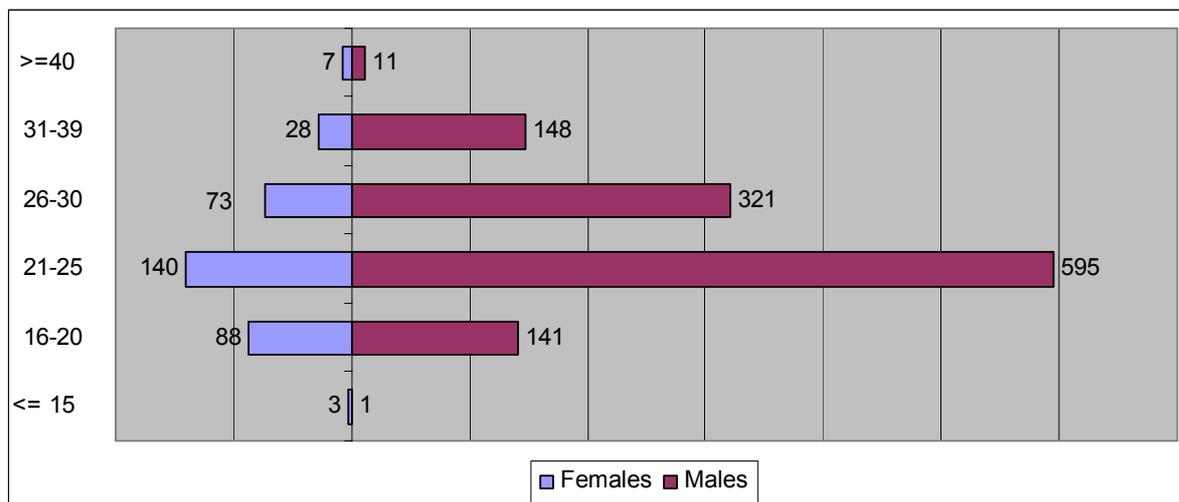
The use of this substance seems to have been increasing in the French recreational scene for several years. In 2004, along with cannabis, this illicit substance is the most likely to be observed within the techno recreational scene. However it appears to be more and more detected in other social areas and particularly among users of risk reduction facilities: in 2003, a cross-survey revealed that 32% of the latter had used that substance during the previous month (Bello *et al.*, 2004). Observations carried out by the TREND network among the recreational scene show that most users stand within the 18-30 year-old age-bracket, and they are mainly well-integrated individuals (students, employees).

Among individuals attending the “electronic music” recreational area 32.4% have used ecstasy during the month prior to the survey, and 10.4% more than once a week. While most of them (83.6%) use it orally, a significant minority (15.4%) sniffs ecstasy. According to the TREND network, the three modes of administration of ecstasy are ingesting, sniffing, and injecting. As in previous years, the first two modes are more widespread in the recreational scene as well as among urban fringe users. Injecting ecstasy remains a fairly atypical

practice, which would essentially concern individuals met within the urban area. In 2002 observations brought out by the network revealed an increase in sniffing ecstasy powder (labelled “MDMA powder”) in the recreational scene.

As stated by SINTES the majority of individuals giving up a sample of ecstasy in 2002/03 are males, whose most significant age-bracket includes the 21-25 year-olds (Graph 12).

Graph 12: Age and gender distribution of users having given up a sample to SINTES, from July 2002 to September 2003



Source: SINTES / OFDT.

Amphetamines

Since 1999 the use of amphetamines in the recreational scene has been likely to extend while mostly remaining among specific subgroups. Their images have seemed to improve since several years. Though they are less famous substances than cocaine, they are considered cheap, efficient, and manageable. These last years the availability of amphetamines has been rather significant in the French recreational area.

In 2004 three sites from the TREND network (Marseilles, Metz and Toulouse) have reported a widening of the usual spectrum of “speed” users towards populations attending commercial raves even clubs, therefore coming close to the medium profile of the ecstasy user. Yet as in previous years that year’s use of “speed” appears to relate to a population of *teuffeurs* rather attending the unconventional recreational scene, and with “nomadic” or “wanderer” profiles. Such a group is somewhat socially insecure and sporadically attends low threshold facilities set up within the urban area.

Among individuals attending the “electronic music” recreational scene 13.4% have used amphetamines during the previous month, and 3.1% more than once a week. An overuse in the free/rave area can be observed when compared with other recreational areas, yet matching the network conclusions. Indeed almost one individual out of three (29.0%) has used that substance in the free/rave area during the month prior to the survey against less than one individual in ten in the three other recreational areas.

Amphetamines are available either in powder or in pill form. According to the TREND network, within the recreational scene the main administering modes are sniffing and ingesting, injection remaining negligible. In fact, during the previous month, among amphetamine users within the “electronic music” recreational area, three quarters of them (74.3%) have sniffed these substances, and almost one quarter (23.8%) have swallowed the latter.

Hallucinogens

They stand for the second family of substances most experimented by users attending the recreational area. They include hallucinogenic mushrooms and LSD, and to a lesser extent ketamine, other substances (GHB, plants...) remaining uncharacteristic. Their distribution seems to have increased these last years. However their evolutions prove fairly mixed according to the different substances. While their recent use can be observed in all the "electronic music" recreational areas, it appears to occur notably among *free-parties* and rave parties fans. Yet the use of hallucinogens remain mostly sporadic, as their effects recurring frequently cannot generally fit the user's social life.

Hallucinogenic mushrooms

Since several years hallucinogenic mushrooms benefit from a positive image among users because of present craze for natural substances, disconnected from other drugs (ecstasy, cocaine...) trafficking. However their use remains restricted on account of their effects.

More than half (54.9%) of the individuals surveyed within the "electronic music" recreational area have tasted hallucinogenic mushrooms. As far as experimenting is concerned, a great diversity can be observed depending on what kind of party is at stake. Actually among the free/rave goers, eight individuals out of ten (81.1%) have tasted these substances, 56.2% of them within the urban scene, and a bit more than one third (37.0%) in a "VIP club" and among clubbers (35.2%). While on the whole a bit more than one individual in ten (12.4%) have used these substances during the month prior to the survey, that includes almost one fourth (24.8%) of people attending the free/rave area. Mushrooms are almost exclusively (97.1%) used orally yet some individuals smoke them.

LSD

During last five years the use of LSD in the French techno recreational area has been varying, mainly because of the erratic availability of the substance. It had nearly disappeared in 2002 then came back in 2003 before remaining intermittently depending on locations and periods. Despite its status of a substance producing "strong" effects, LSD is very well-perceived among users. Its implicit scarcity and aura of a mythical substance, relating to 60's and 70's counterculture, enable its users to stand out.

The levels of experimentation vary from more than two thirds (71.4%) of the free/rave scene individuals to less than one fourth (22.8%) of "VIP clubbers". The use during the previous month relates to nearly one individual out of ten (10.5%); it mostly concerns people attending the free/rave area. As a matter of fact, according to the TREND network, in 2004 LSD users mostly include young males who are *free-parties* fans and often experiencing an insecure socio-economic condition. As the network would report it, the "bad trip" stands for the main effect unsought for, yet its frequency is not documented.

LSD is essentially available in blotting papers yet also in fluid form ("drops") or micropoints. In 2004 a blotting paper would usually cost between € 10 and €15. According to the TREND network and the "electronic music" survey, the administering mode is exclusively oral (100%). Injection, incision, or application to the eyeball seem to be almost not practised.

Ketamine

According to the TREND's sites network, it remains a substance with an erratic and negligible availability. Its image is still varying among users. While ketamine is rather well-perceived between ketamine's users, because of its status of an exceptional and exclusive substance, it always appears among others users as a substance whose effects cannot be controlled, incompatible with the party spirit.

In 2004 observations issuing from the TREND network corroborate conclusions made on the previous years which report a use focusing on a very specific chunk of the population attending the techno recreational scene. The latter mostly includes "nomads", "travellers", who belong to the underground of the techno movement. This is supported by the results

from the ketamine survey among 250 users of that substance, which shows that 84.3% of them have attended more than ten *free-parties*, and 52.8% more than ten raves (Reynaud-Maurupt and Akoka, 2004). In the “electronic music” area the overall prevalence of ketamine experimentation amounts to 16.4%, yet to 32.1% among individuals attending the free/rave area. The use on the previous month goes from 2.3% for all respondents to 6.5% of the free/rave goers.

The use of ketamine is therefore essentially observed within locations attended by such populations, namely *free-parties* and teknivals. Concerning the spectrum of common users, only Bordeaux, Marseilles and Paris observers report a broadening in progress towards better integrated social milieus, as clubbers in Bordeaux, students in Marseilles, or some homosexual populations attending the Parisian recreational scene. However such a phenomenon remains of limited scope.

Ketamine is only available in powder or liquid form. In 2004 the cost for one gram of powder would vary between € 25 and € 60, depending on locations. As reported by the TREND network and the “electronic music” survey, the mode of administration is exclusively sniffing (100%). However some observers report individuals resorting to injection, ingestion, even smoking, but those seldom occur.

Opiates

They form the third family of illicit substances used within the French techno recreational scene. Though uses of opiates are reported from time to time, they remain comparatively insignificant. However there would have been a slight increase in uses during last years. The opiate which is the most closely related to the techno recreational area is the “rachacha”, whose preparation and rites of use enable users to connect with each other.

Heroin has been experimented by about one fourth (23.1%) of the individuals surveyed within the “electronic music” recreational area, and opium and rachacha by 28.3% of them. As for hallucinogens, such experiences occur more frequently among the free/rave goers. Substitutes for opiates in major addiction treatment (high-dose buprenorphine and methadone), whose misuse is reported in the “urban space”, remain barely observed in the techno recreational scene.

Opium and rachacha

Rachacha is an opium preparation appearing in the form of a soft paste of brown reddish colour. It results from a handmade conversion of poppy. In France its use relates more particularly to some techno subcultures.

As in previous years the perception of that substance by users seems rather good, notably because of its “natural” aspect, which would totally mark it off from heroine.

Within the techno recreational scene, despite its scarcity, rachacha would occur more often in the context of *free-parties* and teknivals, which would tend to play “hardcore” music. Its use would rather relate to a population of *teuffeurs* close to “nomads” and “travellers”. As a matter of fact, in the “electronic music” survey the use during the previous month concerns 4.3% of the respondents, yet 8.6% of users met in a free/rave context. It frequently involves sporadic uses. The most common modes of administration include ingestion (56.5%) and smoking (43.5%).

The use of rachacha would seem to work the same way as heroine, that is to adjust the intakes of stimulants and control the following “comedown” : *“the effects depicted by users are drowsiness, some well-being, an impression of weightlessness (a feeling to walk on a soft ground) [...]”* (Bello *et al.*, 2005c).

In 2004 as in previous years, most of observers from the TREND network give an account of a decrease in the availability of rachacha within the techno recreational scene. For the third year running this opiate is then regarded as scarce.

Heroin

During last years, in the French recreational area, resorting to administering modes other than injection (sniffing and smoking) and to the word *rabla* (“powder” in Arabic), less connoted than “heroin”, make its use comparatively commonplace within some milieus. In 2004 the situation is the same as in the previous years: heroin remains a somewhat tabooed substance yet its distribution carries on under the *rabla* label.

In the “electronic music” survey the amount of users during the previous month is comparatively low (6.7%) yet twice as high (15.5%) among *free/rave* goers.

The modes of administration are the following: first sniffing (69.9%), then smoking (23.6%), and more infrequently injection (5.7%). In the “urban area” injection prevails.

As in previous years, the occurrence of heroin within the techno recreational scene seems to have become commonplace, and notably in teknivals and *free-parties*. For a chunk of the population attending such events, heroin would turn out to be a substance in its own right, whose use would no longer be restricted to adjusting the one of stimulants as cocaine, ecstasy, or speed.

Conclusion

Individuals attending the techno recreational scene use more illicit substances, and on a more frequent basis, than the general population within the same age-bracket. The substances mostly used include first alcohol and tobacco, then cannabis. Among the illicit ones other than cannabis, stimulants and hallucinogens have seemed to be on the increase for last years.

While strategies of risk reduction have now been granted a legal framework, field actions are essentially carried out by non-governmental organizations. A stronger involvement from professionals and public contributors could make possible some advancement in depicting then evaluating actions of information, prevention and risk reduction among these populations.

Some part of the attendance of the techno recreational area is experiencing — or is likely to experience — a problematic use with one or more psychoactive substances. Beyond the risk reduction actions operated among such populations, that conclusion also raises the problem of identifying the individuals having the most difficulties with their uses, and the strategies to develop in order to give them access to a personalized care.

August 2005

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PART C: BIBLIOGRAPHY AND ANNEXES

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15. Annexes

15.1 List of standard tables and structured questionnaire relating to the different sections of the report

Section	Standard Table	Structured questionnaire	Web link
Section 1: National policy and context			
Section 2: Drug use in the population	no. 1: population survey on drug use no. 2: school survey on drug use (ESPAD) no. 30 : Methods and Results of youth surveys		http://stats04.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=5324&sLanguageISO=EN
Section 3: Prevention		no. 22: universal school based prevention no. 25: community-located prevention no. 26: selective and indicated prevention	
Section 4: Problem drug use	no. 7: national prevalence estimates no. 8: local prevalence estimates no. 17: new developments in drug consumption		http://stats04.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=5386&sLanguageISO=EN
Section 5: Drug-related Treatment	no. 3: characteristics of people starting treatment no. 4: evolution of treatment demand Treatment demand indicator (TDI) no. 21: treatments availability	no. 27: treatment programmes	http://stats04.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=5402&sLanguageISO=EN
Section 6: Health correlates and consequences	no. 5: drug-related deaths no. 6: evolution in drug-related deaths no. 18: mortality among cohorts of users no. 9: prevalence of infectious diseases (HIV, HCV, HBV)		http://stats04.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=5315&sLanguageISO=EN http://stats04.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=5335&sLanguageISO=EN

		uageISO=EN
Section 7: Responses to health correlates and consequences	no. 10: syringes exchange distribution and sale no. 23: harm reduction measures to prevent infectious diseases among drug users no.29: reduction of acute drug-related deaths	
Section 8: Social correlates and consequences	no. 11: arrests for drug law offences no. 12: drug use among prisoners	http://stats04.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=5307&sLanguageISO=EN http://stats04.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=5397
Section 9: Responses to social correlates and consequences		
Section 10: Drug Markets	no. 13: quantity and number of seizures no. 14: purity of illicit drugs no. 15: composition of tablets no. 16: prices of illicit drugs	http://stats04.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=5350&sLanguageISO=EN

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15.4 List of acronyms

AAH	Adult disability allowance
AFSSAPS	French Health Products Safety Agency
ANAES	National Agency for Health Accreditation and Evaluation
ANIT	National Association of Drug Addiction Workers
ANPAA	National Association for the prevention of alcoholism and addiction
ASSEDIC	French unemployment benefits department
ASUD	Drugs users' self-support association
CAARUD	Reception and risk reduction support centres for drug users
CAMPS	Early Medicosocial Services Centres
CAST	Cannabis abuse screening test
CCAA	Outpatient Alcoholism Treatment Centres
CDAG	Anonymous free screening centre
CDO	Departmental agreements on objectives in Health and Justice
CEIP	Drug Dependency Information/Evaluation Centres
CEL	Local educational contracts
CepiDC	Centre for epidemiology of the medical causes of death
CESC	Health and Citizenship Educational Committees
CHRS	Accommodation and rehabilitation center for persons of no fixed abode
CI	Confidence interval
CIFAD	Interministerial training center for the fight against drugs
CIRDD	Centres for information and resources on drugs and dependencies
CJN	National police (criminal) records
CLS	Local security contracts
CNAMTS	National State Health Insurance Office for Salaried Workers
CNRS	National centre for scientific research
COM	Pacific French overseas territories
CPAM	French government department dealing with health insurance
CPDD	Drugs and dependencies project leaders
CRIPS	Network of Regional Information and AIDS Prevention centres
CSAPA	Centres for Treatment, Assistance and Prevention of Addiction
CSST	Specialised centers for drug addicts
DAP	Prison service (Ministry of Justice)
DAPSA	Support Facility for Parenthood and Addiction Care
DATIS	national "Drugs, alcohol and tobacco information service" telephone helpline
DDASS	Direction of Health and Social Affairs at local level - for the Département
DESCO	School education Office (Ministry of youth, education and research)
DGS	General Health department (Ministry of health and Welfare)
DH	Hospitals directorate (Ministry for Health and Welfare)
DOM	French overseas territories
DOs	Drug law offences
DRAMES	Death involving abuse of medicines and substances (AFSSAPS)
DRD	Drug related Death (EMCDDA definition)
DRESS	Directorate for research, studies and evaluation of statistics (Ministry of health and welfare; Ministry of social affairs, labour and solidarity)
DSM	Diagnostic and statistical manual of mental disorders
EMCDDA	European monitoring center for drugs and drug addictions
ENVEFF	National Survey on Violence Against Women
EROPP	Survey on Representations, Opinions, and Perceptions Regarding Psychotropic Drugs (OFDT)
ESCAPAD	Survey on Health and Consumption on Call-Up and Preparation for Defence Day (OFDT)
ESPAD	European School Survey Project on Alcohol and other Drugs (INSERM- OFDT-MJENR)
ESSAD	Specialized Home Care Unit
FFA	French Federation of Addictology

FNAILS	File of Police Questioning for the Use of Narcotics (OCRTIS, Ministry of Interior)
FNES	National Federation of Health Education Committees
FRAD	Anti-drug shift trainers (Gendarmerie)
GECA	Group of Studies on Pregnancy and Addictions
GIP	Public interest group
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HDB	High dose buprenorphine
HIV	Human immunodeficiency virus
ICD	International classification of diseases
IDU	Injecting drug users
ILS	Infringement of drug law / drug offences
INPES	National Institute for Health Education and Prevention (former CFES)
INRETS	National Institute for Research on Transport and Safety
INSERM	National Institute for health and medical research
INVS	National health watch institute
IP	Injection practice
IT	Treatment order
IVG	Termination of pregnancy
JAP	Judge responsible for the execution of sentences
JAPD	Day of defense preparation
LOLF	Organic Law Pertaining to Finance Laws
M€	Million(s) of Euros
MA	Marketing autorisation
MILAD	Mission for the Fight Against Drugs (Ministry of Interior)
MILDТ	Interministerial mission for the fight against drugs and drug addiction
NSP	Needle and syringe programme (also NEP: needle exchange programme)
OCRTIS	Central Office for the Repression of Drug-related Offences
OFDT	French monitoring center for drugs and drug addiction
OPPIDUM	Monitoring of illegal psychotropic substances or those that are used for purposes other than medicinal (CEIP)
OR	Odd ratio
PAEJ	Youth Reception and Counselling Centres
PFAD	Anti drug trainer / police officer
PRAPS	Programmes for access to preventive measures and health care for people in vulnerable situations
PRS	Regional health programmes
PRSP	Regional Public Health Programmes
PY	Person year
RECAP	Common data collection on addictions and treatments
RMI	Minimum income
RRP	Risk reduction policy
SAM	Road Safety epidemiological survey on narcotics and fatal road accidents
SFA	French Society of Alcoholology
SIAMOIS	System of information on the accessibility of injection equipment and substitution products (InVs)
SINTES	National poison/substance identification system (OFDT)
SMPR	Regional hospital medical/psychological services
SMR	Standardised mortality rate
SPIP	Prison service for integration and probation
STD	Sexually transmitted diseases
TDI	Treatment demand indicator
THC	Tetrahydrocannabinol
TREND	Recent trends and new drugs (OFDT)
UCSA	Outpatient treatment/consultation unit
UDC	Coordination Unit for Maternity and Risk Situations
UPS	Care unit for prison leavers
WHO	World health organization
ZEP	Priority education zones
ZUS	Sensitive urban areas
